THE STORY OF CARE'S SUCCESSFUL INTEGRATION OF FAMILY PLANNING AND REPRODUCTIVE HEALTH SERVICES

A Case Study

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by Sandra Wilcox, MPH

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LIST OF ACRONYMS

ADRA	Adventist Development and Relief Agency International
AIDS	Acquired Immune Deficiency Syndrome
ANR	Agriculture and Natural Resources
BHR	Bureau of Humanitarian Response
BP	Best Practices
CA	Cooperating Agency
CARE-MoRR	CARE's Management of Reproductive Risk Project
CBD	Community Based Distribution
CD	Country Director
CPR	Contraceptive Prevalence Rate
CYP	Couple-Years Protection
DfID	Department for International Development (United Kingdom, formerly ODA)
DHS	Demographic and Health Survey
EPI	Expanded Programme on Immunization
FP	Family Planning
FY	Fiscal Year
G/PHN	USAID's Global Bureau, Center for Population, Health and Nutrition
HIV	Human Immunodeficiency Virus
HHLS	Household Livelihood Security
IEC	Information, Education, and Communication
IPPF	International Planned Parenthood Federation
MOH	Ministry of Health
MSPP	Multi-Sectoral Population Programs
MWG	Managers Working Group
NGO	Non-governmental Organization
NMH	Neonatal and Maternal Health
NPC	Networks Partnership Council
ODA	Overseas Development Agency (United Kingdom, now DfID)
PAD	Program Analysis and Development Group (formerly TAG)
PATH	Program for Appropriate Technology in Health
PFPE	Population and Family Planning Expansion Project
PHC	Primary Health Care (Unit)
PIR	Project Implementation Report
PSI	Population Services International
PVO	Private and Voluntary Organization
RH	Reproductive Health
RTA	Regional Technical Advisor
SEAD	Small Economic Activity and Development
STI	Sexually Transmitted Infection
TAG	Technical Assistance Group (now PAD)
UNFPA	United Nations Fund for Population Activities
USAID	United States Agency for International Development
VPP	Vice President for Programs

EXECUTIVE SUMMARY

Over the last seven years, CARE USA successfully integrated family planning and reproductive health into its worldwide programming. This case study describes the process of this integration and explores possible implications for donors and other organizations.

Historically, CARE benefited from a strong and early interest among senior management to develop a technically sound population and family planning program. Board members and managers recognized the important links between family planning and other development areas. CARE adopted an official population policy statement in 1990—based on an earlier version drafted in 1975.

The strong support for this initiative from executive leadership and field-based senior managers led to the submission of an unsolicited proposal to the United States Agency for International Development's (USAID's) Office of Population. This resulted in the Population and Family Planning Expansion Project (PFPE) which was funded by a cooperative agreement between CARE and USAID. The five-year project officially began in May 1991.

Through PFPE, CARE successfully integrated family planning and reproductive health programming into the organization by building the technical capacity in headquarters and the field. CARE was also able to build upon the funding received from USAID and leveraged more than three times the amount of match funding it had originally proposed. CARE has disbursed over $19 million in matching funds since 1992, far in excess of the required match of $11.6 million required. This supported the expansion of PFPE from 10 family planning projects in 10 countries to 46 family planning and reproductive health projects in 29 countries. At present, only 8 of these programs are supported by USAID CARE-MoRR. These programs have had substantial impact on modern contraceptive use (ref. figures I and II). Family planning and reproductive health programs are also being developed in other sectors at CARE (food assistance/Title II, girl's education, and agriculture) independent of the CARE-MoRR project.

CARE's current level of technical and program capacity in the area of family planning and reproductive health is the result of a process that took place over seven years. Several factors contributed to the success of this initiative, including the early and strong support from the Board as well as from senior executive and program staff, an interest from the field in developing family planning programs, and the development of solid technical expertise at CARE headquarters to support field initiatives. Also key were the good relationships that CARE forged with the donor, which included early and consistent dialogue on key technical and administrative needs.

Another strategy used by CARE was to initially focus on a small number of projects in order to build on and demonstrate early successes in the program. This entailed starting with country offices where there was a clear interest in family planning and developing a small, but technically sound project portfolio. There was a strong emphasis on learning from the process itself, which included participatory and collaborative approaches, and using this knowledge to improve performance. The headquarters technical team also demonstrated their "added value" by being responsive to field needs, and providing both financial support and a variety of technical assistance to country office projects. The technical assistance was also tailored to respond to specific requests from the country offices.

Along with these efforts, the Population Unit of CARE also defined a clear strategy for constituency building within CARE itself, which entailed fostering links with other units in the organization to better support the family planning program. CARE also actively endorsed family planning programs within CARE International, and this process helped CARE to diversify technical and financial support for the program.

As the project portfolio grew, headquarters and regional staff evolved to meet field needs and provided diversified technical skills and regional expertise to better serve country office needs. Continued political support from CARE leaders was key in maintaining the momentum and interest at an organizational level. This support also proved useful in encouraging more country offices to consider adopting new and innovative programming initiatives in reproductive health and for thinking strategically about these areas when engaging in long-range planning. The evolution in CARE from a family planning focus to one which more broadly addresses reproductive health reflects the Population Unit's efforts to better integrate with country office needs, and the overall context of health programs.

Over the years, CARE made technical and administrative adjustments to respond to the internal changes within USAID. One change hasbeen the creation of the center for population, health and nutrition (G/PHN Center) in 1994, with its mission of global technical leadership. Another change has been the decentralization of authority and resources to USAID field missions and the establishment of two separate funding sources for USAID-supported initiatives: G/PHN Center core funds and USAID mission field-support funding. This has meant carefully planning the use of core funds to strategically support USAID mission programs. Another change has been the development of strategic objectives at all levels (Agency, G/PHN Center and USAID missions) and the related requirement that all G/PHN centrally-funded activities be consistent with and support USAID field mission strategies. Very importantly, the strategic planning process has increased accountability for results at all levels. Finally, there have been significant changes in the external environment, with an increase in congressionally-mandated restrictions on USAID population funds (metering) and program (Tiarht Amendment).

Other adjustments have included expanding the monitoring and evaluation system to capture key reproductive health indicators beyond family planning. CARE is also supporting a number of program innovations including partnering strategies, peri-urban program, and operations research with cooperating agencies. A key factor in this process has been the importance of keeping headquarters flexible to respond to different organizational levels: management, technical program structure, and the field.

CARE's experience has implications for other private and voluntary organizations (PVOs) seeking to build organizational commitment and capacity in family planning and reproductive health:

- The decision to expand into this new technical area came from within the organization itself. This decision evolved from a recognition of the important links between family planning and other development programs.
- Strong political support for this initiative from key members of the Board, senior executive and program staff, and field directors was key to the success of this initiative.
- The strong technical team established in headquarters was important to the success of this program.

- CARE deliberately began its program with a small number of technically sophisticated and successful projects that could serve to convince others in CARE that family planning was a viable program area.
- The technical unit in headquarters developed a strategy for ensuring that that program was widely accepted and funded. This entailed identifying internal and external constituencies, which the Population Unit then used to focus education and advocacy efforts to build support for the family planning program.
- CARE emphasized learning from the process itself. It did not present itself as "the expert" but sought to emphasize the advantages offered by a large development agency: global infrastructure, committed country office staff, and the ability to work in remote areas. This "learning organization" approach encouraged CARE to take risks, look outside of CARE for needed expertise, bridge research and field work, and build upon the learning process itself to improve program approaches.
- CARE actively sought ways to make the project attractive to field offices. In addition to funding, CARE offered a number of technical tools, standards, and workshops; helped with recruitment; and disseminated technical information to support field programs.

CARE's experience also highlights a number of implications for the NGO Networks for Health Project, including:

- Building organizational commitment to a new programming area takes time. NGO Networks can help facilitate this process within each partner and develop mechanisms for fostering commitment to the network (i.e., working collaboratively) and to the Networks Project itself. The Networks Project can play an important role in keeping the Partners focused on these issues via the Managers Working Group and the Networks Partnership Council.
- A strong relationship between the implementing agency and the donor can contribute a great deal to the success of a program. NGO Networks can help the Partners better understand the implications of working collaboratively with USAID's Global Bureau, Center for Population, Health and Nutrition (G/PHN) as well as coordinating effectively with other units of the agency (family planning, maternal health, child survival, HIV/AIDS).
- Fundraising for the PFPE match fund was strengthened by joint programming and leveraging of funds. CARE created a marketing plan to reach donors and drew upon alliances within CARE International to help raise matching funds for the PFPE project. The Networks Project can facilitate dialogue within and among the Partner PVOs and assist with creative solutions on how the match might be raised and then programmed to best leverage resources and expand FP/RH programming.
- It was useful to have an appropriate mix of staff (with different backgrounds, areas of expertise, and familiarity with CARE) on the team that developed and supported the program. The Networks Project should carefully consider this issue in terms of its own long and short-term staffing needs, and consider how to advise Partner PVOs on these issues.
- The CARE experience has shown the importance of providing strong technical input to country programs. The Networks Project can learn from this experience as it structures its technical assistance to Partner PVOs.
- *Embracing errors*, one of the concepts that comes from CARE's *learning organization* philosophy, became an effective way to improve and strengthen program approaches. NGO Networks can

help further this thinking with its partners and should act as a catalyst and facilitate a process of experimentation, reflection, and learning among the five PVO Partners.

- Success in building PVO/NGO capacity in health programming is based on good relationships at several levels: with the PVO field offices, with the local USAID Missions, with the PVO partner headquarters, and with USAID's G/PHN Center. Among the PVO Partners, the Networks Project can play an important role in making this happen.

I. INTRODUCTION

A. Background

In 1990, CARE USA submitted an unsolicited proposal to the Office of Population of the United States Agency for International Development (USAID) requesting support for family planning programming efforts. Through this project, CARE hoped to contribute to the global expansion of family planning services by developing the agency's institutional capacity to manage and operate family planning services.

The resulting seven-year (May 1991-June 1998) cooperative agreement established the Population and Family Planning Expansion (PFPE) project. Through PFPE, CARE USA successfully integrated family planning and reproductive health programming into the organization. CARE was also able to build upon the funding received from USAID to leverage more than three times the amount of match funding they originally proposed, which allowed the expansion of PFPE from initial support of 10 family planning projects in 10 countries to 46 family planning and reproductive health projects in 29 countries. CARE's success in integrating family planning and reproductive health into its global programs serves as an example of what can be accomplished by a strong partnership between a highly motivated development and relief agency and an interested, technically sophisticated donor.

B. Contributing to Another Innovative Project

When designing the NGO Networks for Health project (NGO Networks), USAID drew upon CARE's experience in strengthening organizational commitment and building technical and programming capacity. NGO Networks is a five-year project designed to upgrade the information and service delivery capacity of a number of large community development agencies in the areas of family planning, reproductive health, child survival, and human immunodeficiency virus (HIV). It focuses on building networks of organizations working in tandem to ensure greater availability, access, and quality of information and services for men and women in several countries.

NGO Networks is a partnership among five leading US development agencies: the Adventist Development and Relief Agency International (ADRA), CARE, PATH (Program for Appropriate Technology in Health), PLAN International, and Save the Children USA. The project is administered under a cooperative agreement between Save the Children USA and USAID's Global Bureau, Center for Population, Health and Nutrition (G/PHN).

One of the objectives of NGO Networks is to gather useful lessons and experience and share them with other agencies in order to strengthen programming. This is the first of a series of publications that the Networks Project will produce to contribute to improved family planning and reproductive health services and to the use of partnerships as a means of providing better services. A description of NGO Networks is provided in Annex A of this report.

C. Sharing the Lessons

This case study describes CARE's experience with PFPE—how the agency went about garnering internal commitment (both in headquarters and the field offices) for the effort and ensuring that their staff had the capacity to do the work well. It documents the process, key issues, and challenges. It also

looks at how CARE built its relationship with USAID and coordinated its overall development strategies with those of a donor with its own development agenda. The relationship between CARE and USAID is different from other relationships between USAID and contractors, grantees, and partners and may, therefore, be useful in defining future agreements.

It is important to note that this document is not an evaluation of CARE's PFPE project. Numerous evaluations and reports related to the project (many of which are cited in this document) have been published. NGO Networks believes that the documentation of CARE's experience with PFPE in building institutional commitment and capacity in family planning and reproductive health programming, will be useful for other private and voluntary organizations (PVOs) that are considering expanding their efforts in reproductive health and strengthening their capacity to program effectively in this area. Because this case study focuses on issues related to integrating a sensitive health area into an organization with many other development priorities, it will be particularly useful to organizations with integrated program strategies. Discussion of the partnership between CARE and USAID (and subsequent relationships between CARE and USAID's cooperating agencies) may be of interest to USAID and its cooperating agencies as well as to other donors desiring to support family planning and reproductive health projects with PVOs. This publication could also be useful to NGO Networks partner PVOs and other potential partners—helping them understand how the process unfolded in CARE, the key issues and challenges they might face when planning similar efforts to emphasize reproductive health, and the implications for moving forward.

D. Gathering the Information

To gather information for this publication, the author:

- Reviewed numerous documents produced by CARE and other agencies.
- Attended a two-day team planning meeting in Washington D.C. with staff from CARE and NGO Networks, to clarify the scope of work, purpose and objectives, and define the expected outcomes and specific work plan.
- Interviewed USAID/Washington staff who were involved in the development of PFPE and/or who interacted with it in the field while it was evolving.
- Talked with members of cooperating agencies (CAs) who had worked with CARE field projects or on CARE evaluations.
- Interviewed past and current CARE headquarters staff in Atlanta and CARE field staff in a variety of locations.

The scope of work for this report, list of persons contacted, and the interview guides are included as Annexes B, C, and D of this report.

E. Using this Publication

The PFPE case study is organized into four major sections:

1. History of the PFPE Project
2. Key Events of Institutional Change
3. Implications for PVOs
4. Implications for the Networks Project.

The first section, *History*, discusses the evolution of CARE's PFPE project and is divided into four parts, the pre-project phase (before 1991), the beginning of the USAID-funded project (1991-1993), the consolidation of the first stage of the PFPE project (1994-1995), and the expansion of the project into

reproductive health through the PFPE two-year extension (1996-98).

The second section, *Key Events of Institutional Change*, is a brief summary that synthesizes major activities that led to institutional change. Next is *Implications for PVOs*—a discussion of what CARE's experience with PFPE might mean for other PVOs who are considering similar programmatic expansions. This is followed by *Implications for the Networks Project*—a brief discussion of this experience in the context of the NGO Networks Project, focusing specifically on lessons that might facilitate the institutional change process that NGO Networks partners might face.

II. CARE'S STORY—HISTORY OF THE PFPE PROJECT

A. Before 1991: Early Interest at the Top

CARE is an international relief and development agency that was founded in 1945 to provide relief assistance to survivors of World War II. Over the years, CARE has adapted its agenda to meet the changing human needs and evolved its technical programming sectors to respond to larger health and development issues worldwide. CARE USA is part of an international network made up of 10 CARE agencies located in Australia, Austria, Canada, Denmark, France, Germany, Japan, Norway, the UK, and the USA. Each CARE entity supports the implementation of relief activities and development projects throughout the developing world.

CARE USA (hereafter referred to as "CARE") officially adopted a population policy in 1990. However, the history and evolution of the organization's interest in population and family planning is an important part of the story.

From 1945 until the 1970s, CARE was predominantly an emergency relief organization, and its main activity was food distribution. Beginning in the late 1970s, CARE began to broaden its orientation. During the first stage of this expansion, CARE created three new sectors:

- Agriculture and Natural Resources (ANR);
- Small Economic Activity and Development (SEAD); and
- Primary Health Care (PHC).

To support these sectors, CARE established technical units within the Technical Assistance Group (TAG) department, which advised CARE programming strategies worldwide.

PRE-1991 KEY EVENTS

- Early and strong board support for family planning.
- Strong interest from key field staff in family planning programming and its relationship to development.
- Early development of a clearly articulated policy statement on population.
- Testing of donor reactions to family planning programming.
- Strong executive leadership support for developing CARE's population program.
- Key staff assigned to develop CARE's program.
- Time devoted to defining CARE's population policy, building relationships within CARE, and with USAID CAs in order to explore technical support needed to implement population programs.

Interestingly, a major portion of the TAG department and its formation was supported by *seed* grants from USAID, first with ANR and later with SEAD. Therefore, when population was identified as a potential program area, a precedent already existed to establish a technical unit and to approach USAID for seed money with which to get the program started. CARE had a long history of successful collaboration with USAID. Presently, somewhat more than half of CARE USA's funding comes from USAID.

Interest in family planning evolved at CARE along several lines. CARE is a major provider of food aid worldwide, supported through USAID's Title II program. Because Title II's monetization into local currency allows funds to be spent on development efforts, many of CARE's programs (e.g., agriculture, water, construction, and health care) began from this source. A variety of other CARE donors (for example Dutch and Norwegian foreign aid

agencies) also supported integrated development efforts. Some of CARE's integrated programs included family planning-related components, particularly in countries such as India and Bangladesh where population was part of the national agendas. So even though CARE formally adopted their population policy in 1991, it had some experience with population-related programs earlier.

In addition, CARE USA's Board of Directors raised the issue of family planning during the 1970s as a key program area to be addressed by CARE. One Board member, Ed Wesley, was particularly interested. He was charged with researching the need for family planning and identifying the issues, potential benefits to CARE, and recommendations (see box this page).

Both program and management sectors of CARE came to recognize the importance of family planning and its implications for development. In the mid 1970s a policy was presented and endorsed by the Board. Memorandums were sent out to country offices recommending their participation in family planning programs and providing instruction on how to implement them.

Despite the fact that this policy was developed in the mid to late 1970s, it took several years for it to be accepted as an integral part of CARE's program policy. First, several organizational hurdles had to be overcome. To begin with, there were internal issues related to how best to implement this board-driven policy. Secondly, not all the program directors at headquarters or in the field had fully accepted the program. In addition, there were bureaucratic questions such as, How should it be integrated into CARE's existing structure? How will it be funded? What kinds of changes to CARE's organizational structure will be needed to accommodate this new program entity?

Another factor that delayed its acceptance as a program was the fact that, in the United States, family planning was overshadowed at the time by a raging debate over abortion. Up until then, CARE had successfully implemented family planning programs, especially those that involved education, without becoming involved in the issue of whether CARE should promote or further abortion. However, by the mid 1980s it was difficult to advocate family planning and not take a position on abortion. CARE's Board of Directors was involved in the debate because they had to deal with donors. CARE's donors had positions that crossed the continuum. Some were opposed to family planning; others were in favor of abortion and sterilization. The Board and staff were charged with finding a path through this set of conflicting positions on abortion.

KEY POINTS OF MEMO TO CARE'S BOARD OF DIRECTORS

The Macro Situation

- The magnitude and rate of population growth in developing nations are without historical parallel.
- The high rate of population growth is attributable to the continuing gap between fertility and mortality, though both have declined rapidly.
- Population growth is inevitable, but the degree of growth can vary substantially depending upon the pace of fertility decline.

The Micro Situation

- Birth rates are essentially determined by two factors: (1) the status and socioeconomic context of women; and (2) access to family planning services.
- Improvements in both these areas need to be made in order to reduce birth rates—neither alone will suffice.

Why CARE Should Be Concerned about Population Growth

- High fertility contributes to high rates of infant and maternal mortality.
- There is a high unmet need for family planning services.
- Rapid population growth impedes development.
- Rapid population growth contributes to environmental degradation.

For a long time, the debate over abortion within CARE was linked to other health areas, such as women's reproductive health, children's health, immunizations, etc. While the players agreed on issues related to the broader health topics, staff and board members found it difficult to separate out the issue of abortion. In the end, CARE took a position supporting population and family planning but not abortion.

Another event occurring around this time also slowed the process of acceptance. In 1978, CARE started becoming *internationalized,* which meant the inclusion of other CARE member countries into what is now a network of 10 CARE entities. One implication of this change was that all CARE International partners would need to agree with the family planning policy objectives. This was a slow process. However, once accomplished, it laid the groundwork for the future evolution of the program.

These issues—determining where to place the new program, the debate over abortion, and changes to CARE's structure—took several years for CARE to sort out. It wasn't until the late 1980s that CARE was prepared to begin serious consideration of population as a program entity. At this time, some staff at both headquarters and in the field were beginning to recognize that rapid population growth was undermining the accomplishments and impact of CARE's development work. A strategic planning exercise (often referred to as the 1989 Tarrytown Conference) supported this growing consensus. CARE examined its organizational capabilities and comparative advantages and concluded that population and family planning programming should be integrated into CARE's existing portfolio.

Although several country directors and some technical people at headquarters endorsed this decision, there was still resistance to this new program area. Maurice Middleberg notes that [while endorsement of this change was not unanimous,] "there was a strategic process in place, and there was support from CARE's leadership." Some staff members were concerned that the board, which at that time included representatives of several religious groups, might not endorse family planning as an explicit CARE activity. Some of the fundraisers were concerned about possible negative impacts of CARE's entering into family planning. In response to this concern, an informal market study was conducted with donors. This study indicated that any impact of this decision would probably be mildly positive, although there were a few large donors that were opposed to family planning.

After this long process and many iterations of the 1975 version, CARE's Board of Directors adopted a population policy statement in 1990 (see box next page).

By late 1990, the CARE Program Manual included a "Population Strategy," which put together the rationale, goals, and strategy for CARE's involvement.

After the Tarrytown meeting (and at about the same time that the population policy was being finalized), CARE decided to begin developing a population program. At this time, the chairman of the Board of Directors was Ed Wesley, and Peter Bell was preparing to take over that role. Both men continued to push a family planning agenda from the board level. CARE's Executive Director at the time was Phil Johnston—who also believed strongly in the need for family planning programming. Mr. Johnston had worked for several years with CARE in India and had seen how quickly development gains can be overwhelmed by uncontrolled population growth. The head of the TAG, Sandy Laumark, was another strong supporter of furthering the family planning directive of CARE. Ms. Laumark had started one of CARE's first family planning and

reproductive health projects in Bangladesh in 1980. She assigned Susan Toole, from CARE's Primary Health Care Unit, the task of starting the program development process. Ms. Toole had been working with CARE for a number of years and was looking for a new program area.

Ms. Toole, Ms. Laumark, and other CARE staff developed an unsolicited proposal for USAID's Office of Population. The proposal process took about a year, and during that time, CARE educated itself about what would be required to develop the technical capacity to implement a population program. This education process involved reviewing documents and meeting with several of USAID's cooperating agencies (CAs). The process enabled CARE to figure out how best to design a program that would both fit with USAID's requirements and objectives and would be consistent with CARE's priorities. The proposal was submitted to USAID in December 1990.

CARE'S POPULATION POLICY

CARE believes that poverty and rapid population growth are synergistically related. The combined effect of these two forces impedes the achievement of economic and social well being.

According to the United Nations Fund for Population Activities (UNFPA), there are five factors that determine fertility and hence affect population growth:

- Woman's status
- Maternal and child health
- Information about access to family planning
- Family income
- Female education.

Given that CARE is a development agency, and given that men's and women's decisions about family planning are best made in a context which is favorable to development, CARE seeks to support activities in all sectors, which will positively affect the five fertility factors mentioned above.

CARE is active in the area of reproductive health education and service, both through its own programs and in cooperation with other entities in the host countries where it operates. CARE upholds the rights of nations and their people to identify their own problems and formulate responses to them, while recognizing the right of every man and woman to unrestricted access to all methods and means of family planning information and services. CARE's support and services are and will continue to be governed by local laws, customs, religious beliefs, international health standards, and, most importantly, by the voluntary choice of individuals.

B. The Launch (1991-1993)

USAID's Office of Population reviewed CARE's proposal in February 1991, and several months later signed a cooperative agreement establishing the Population and Family Planning Expansion Project (PFPE). The official dates of the five-year project were May 1, 1991, through April 30, 1996. The life-of-project budget was $32.9 million—$25.8 million to be provided by USAID ($17.8 million in central funds and $8 million in buy-ins) and $7.1 million to be provided by CARE.

The project's stated goal was to expand the use and availability of family planning services and to improve the quality of services delivered. Two strategies were outlined in the proposal to achieve this goal: institutionalizing family planning in CARE; and expanding family planning service delivery through CARE's infrastructure. The shared vision of the Office of Population and CARE was that population assistance become as much a part of the fabric of CARE's work as its well-known activities in emergency assistance, primary health care, credit and micro-enterprise, and agriculture. As discussed in the previous section, integrating population into a large, decentralized organization such as CARE posed special challenges and required a significant investment of time and resources.

There were several reasons that the Office of Population was interested in this project. According to Sandy Laumark. "....CARE was a major generalist development organization with existing capacity in scores of countries, a good track record in rural areas, in logistics, and with the local governments, and with the possibility of securing significant non-USAID funds. Thus, for a relatively small investment, the Office of Population could develop another FP agency to complement the existing stable of USAID funded FP [family planning] agencies (Pathfinder, PSI, IPPF etc)..."

KEY ELEMENTS OF THE LAUNCH PHASE

- A dedicated unit established at headquarters, staffed with individuals with a mix of tenure in CARE, management experience, and technical skills.
- Focused on building a strong technical team.
- Facilitated early and consistent dialogue with the donor to determine the key technical and administrative needs in the field and at headquarters.
- Demonstrated early successes by starting with a small, but technically strong, project portfolio.
- Emphasized the importance of learning from the process; did not expect to be instant experts.
- Encouraged participatory approaches for monitoring and evaluation. Built on stakeholder involvement and input.
- Field presence created in country offices where there was an expressed interest in family planning.
- Tailored technical assistance to country office requests.
- Promoted the importance of population activities within CARE.
- Developed strong linkages with CARE International, in order to diversify technical and financial support for the program.
- Assisted country offices to build relationships with specific CARE International partners in order to raise funding for family planning-related initiatives.

Key Lessons

- Integrate the program approach with field strategies and needs.
- Build strong relationships with USAID country and regional offices early in the life of a project.
- Ensure that headquarters staff have a good understanding of how the field offices work—funding and program mechanisms, administrative procedures, organizational structures, etc.

B1. Staffing

The first step in the institutionalization process was to develop an administrative unit, the Population Unit. CARE decided to create a separate unit instead of including it in another unit such as primary health care (PHC). This was done to underscore its importance as a major organizational priority, to make it more

visible both internally and externally, and to give it room to develop its own direction. Susan Toole was made director of this unit and soon hired two core headquarters staff for the project, Therese McGinn (deputy director) and Maurice Middleberg (senior population advisor). Both of the new staff came from outside CARE and brought special family planning technical expertise to the project. They had worked with family planning cooperating agencies and were familiar with USAID and the Office of Population. The three staff comprised a very strong team for initiating the project.

Ms. Toole was a CARE insider who had support at the top and also knew how to work the CARE system in order to get programs launched. She had an MPH and had previously been the deputy director of the PHC Unit. Ms. McGinn had an extensive operations research background (with the Columbia University Operations Research Project) developed through years of work in Africa. She clearly understood the kinds of technical inputs needed to make family planning work at the field level. Mr. Middleberg had been Director of the Options Program and had a policy and advocacy background. He also understood how USAID missions operated, having been the USAID Population Coordinator in Niger. In addition, he understood the importance of developing technical tools for program staff.

In addition to the headquarters team, three Regional Technical Advisors were hired for Africa and Asia. The unit also helped recruit technical staff for country office population projects. Hiring technically qualified senior staff for this project was one of the first challenges faced by the project. Traditionally, CARE had a tendency to hire more junior staff and then train them on the job, so questions were raised about the need for senior-level staff. The response was that while CARE had years of experience in the other programming areas (water, agriculture, forestry, etc.) with experienced staff who could train new staff, this was not the case with population. Family planning, in addition to being a new area for CARE, was also a politically sensitive area that required experienced personnel who could provide technical expertise in its implementation. Also CARE staff had developed good communications with the technical experts in the Office of Population and, through open dialogue, were able to draw on their considerable experience and expertise in implementing successful population programs. This input highlighted the need for experienced, technical staff.

B2. Project Design and Technical Focus

Given the difficulties of starting a new project, project staff decided early in the process that they needed to develop a small number of projects that were technically sound and consequently successful, in order to convince CARE that family planning was programmatically viable. The original PFPE project design called for the implementation of 16 field projects predominantly in sub-Saharan Africa. However just as the first four country projects were being launched in 1992-93 (Niger, Rwanda, Togo, and Uganda), the Office of Population changed its focus and adopted its Big Country Strategy. To accommodate this new strategy, CARE USA agreed to shift its focus and concentrate on fewer but larger projects in more demographically significant countries. As a result, the Office of Population and CARE agreed to reduce the expected number of PFPE-funded projects to 10.[1]

The team was strategic in its development of country projects. CARE's Population

[1]Although CARE agreed to centrally fund and implement projects in 10 countries in adjustment to USAID's Big Country Strategy, initially projects were only ready to be implemented in 8 countries. Two other countries were added later.

Program was shaped by a conceptual framework consisting of five interrelated elements: policy, strategy, guidelines and tools, projects and services, and learning. Underlying all aspects of the development of CARE's Population Program and the PFPE project has been a "learning organization" approach. This has involved looking outside CARE to the larger population and family planning community for information and lessons learned, as well as within CARE to other sectors. It has also meant examining programmatic weaknesses and mistakes as well as successes. CARE uses the phrase "embracing error to improve practice." Included in the learning organization approach is a collaborative approach to monitoring and evaluation that attempts to involve all relevant stakeholders and then constructively uses knowledge gained to improve performance.

An example of how this learning organization approach benefited CARE's program development is the way they employed it in their relationship with USAID. CARE could tell USAID that they were not experts in family planning and that they needed guidance and direction. USAID encouraged and was very responsive to this approach and either provided the needed guidance or put CARE in touch with the required technical expertise.

The project staff were also very strategic in how the approached the country offices. As Therese McGinn pointed out, "The attitude of the headquarters staff was very low key and they only went into countries where the country directors wanted the program." Second, they had several things to offer the countries where they did intervene. They had money from PFPE to support project activity. Although later several country offices raised their own funding for project activity, at the beginning this was a big motivator. In addition the Population Unit offered a whole range of technical aids in order to get the country projects started. They had regional technical advisors (in addition to the headquarters staff) who were available to assist in programming and they were completely paid for by PFPE, unlike other regional technical advisors in CARE who had to be paid by the individual CARE missions. In addition, the headquarters staff had developed a series of technical standards and tools to support project managers and staff and guide the implementation of CARE's Population Program. Topics included:

- Design guidelines for population project proposals
- "How to" guidelines for behavioral change
- Budget, procurement, and travel guidelines
- Developing successful information, education, and communication (IEC) programs: guidelines for program managers
- Training guidelines
- Quality of care supervision tool
- Service statistics
- Monitoring and evaluation guidelines
- Assessing management capacity among nongovernmental organizations (NGOs)
- Project Implementation Report (PIR) format
- Portfolio analysis questionnaire
- Population sector guidance for strategic plan.

In addition to these materials, the Population Unit also sponsored a number of technical workshops to address specific issues. Headquarters brought in outside experts (often from other population CAs) as well as family planning field project managers and the unit team. The first one was on how to strategize and implement the PFPE Project. Then, in June 1992, a workshop was held in Mombassa that focused on quality of care, service statistics, and project reporting using a

participatory case study approach. In November 1993, the workshop was organized around the theme of "Moving towards Impact" and focused on project progress to date and learning strategies.

In the summer and fall of 1994, the eight PFPE centrally-funded field projects each organized intensive participatory mid-term evaluations involving stakeholders that scrutinized each project's progress to date and led to identification of needed action. Though it took much time and effort, the workshop/ conference mechanism was very effective and manageable because there were still a small number of centrally and mission funded country projects (8 to 12). It allowed the opportunity to collectively analyze and share issues concerning the PFPE Project and field project implementation. It also served as a useful vehicle for consolidating CARE's commitment to population and family planning.

The headquarters staff also regularly updated field staff with professional literature through the Population Packet series and other means so they could stay current.

The provision of technical support to the Country Offices in the design, implementation and evaluation of their family planning projects was seen as the unit's key responsibility. The Unit's annual operating plan outlined specific program support to each Country Office that had or was developing a family planning program. The Unit's management strategy was aimed at helping to develop appropriate short and intermediate range objectives within realistic time frames and then monitor progress to their achievement.

The fact that PFPE had a large centrally funded agreement that allowed it to develop programs in the field and support numerous technical inputs from headquarters and the regions made it very appealing to country offices. It also gave the headquarters staff tremendous freedom to oversee and coordinate the development of the 8 to 12 country projects. No other program at CARE had this level of technical support from headquarters, so in that sense it was very innovative. CARE field staff that were part of these early programs all commented on the usefulness of these technical inputs from headquarters. Diana Altman, the regional technical advisor (RTA) for East Africa stated that "there was a lot of contact between headquarters and the field—not necessarily visits [although there were plenty of those] but they called all the time—they were very accessible."

Another innovation that PFPE attempted was that of cross-sector programming. The idea was for programs to share resources across sectors. Although in most cases it did not get that far and instead became examples of side by side programming on specific projects. More recently, this has become a broader theme at CARE with integrated programming models being advocated such as Household Livelihood Security. At the time PFPE began it was difficult to "make it fit" into the structure of the organization. The resistance was not so much an objection to family planning, although there were those who did object, but more the bureaucratic difficulties encountered when working with a new department. Each sector has different mandates, goals, procedures and they operate on different funding cycles. All of this made unified programming difficult.

B3. Advocacy

The Population Unit focused on another big activity during this period—promoting the program at all levels inside and outside CARE. The newly formed team understood that in order for PFPE to be successful in CARE, it would need to be understood and supported at all levels of the organization.

According to Maurice Middleberg, the team "drew up a map of CARE's internal and external constituencies and developed a communications/promotion strategy targeting each of these." They knew they needed the support of segments such as Country Directors, CARE International, the Board of Directors, key donors, the external relations department, etc.

Team members then began communicating with each of these groups in an effort to convince them to buy into CARE's family planning program. Much of the first two years was taken up with this process. Team members gave representatives of the different segments opportunities to vent their concerns. Sue Toole, the only team member who had previously worked with CARE, played a key role in convincing CARE USA and CARE International. But, she claims that this would not have been possible without the support from CARE's leadership, "Phil (Johnston, executive director at the time) was behind it all the way—a real champion, and Bill Novelli (CEO) was the other champion—he helped with strategy and he believed in family planning."

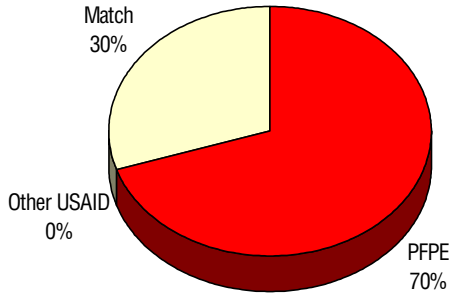
B4. Raising the Match

One of the terms of the proposal was that CARE's funding commitment to PFPE would match USAID's contribution by $0.40 to the dollar. The Office of Population and CARE had a shared interest in diversifying the funding sources for CARE's population program. USAID viewed CARE as a vehicle for leveraging USAID's population money in an era of shrinking resources. CARE had a clear self-interest in ensuring a diverse donor base. As a result, fundraising was a major emphasis of the program.
Much of the match was raised through CARE International. During the 1980s, seven of the countries that first received CARE's assistance founded their own independent CARE organizations: CARE Germany (1980); CARE Norway (1980); CARE France (1983); CARE United Kingdom (1985); CARE Austria (1986); and CARE Japan (1987). These seven together with CARE Australia (1987), CARE Denmark (1988), CARE Canada and CARE USA make up the 10-member confederation that is CARE International.

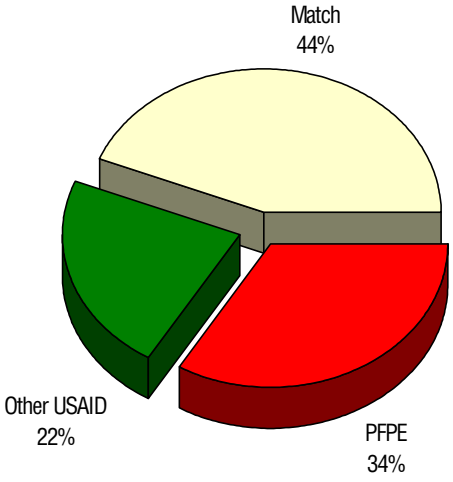
In each developing country where CARE works, there is a *lead member* designated to oversee the management of program operations. Lead members include CARE USA, CARE Canada, and CARE Australia. The other members play important program and liaison roles, especially with regard to fund-raising. For example, CARE United Kingdom (UK) has become a major family planning funding partner with CARE USA. In order to leverage funds for the population and family planning activities, the headquarters team developed a strategy for approaching CARE International. With assistance from CARE USA, CARE International actually developed a Population Policy Statement that was agreed to in 1992. Within CARE USA, making the important links with the External Relations/Marketing unit was quite difficult at first because staff from this department needed a lot of convincing that it wasn't going to lose many of its donors. Sue Toole states that "we could have been better prepared for dealing with the marketing department and could have provided them with more tools." During the first years she and others spent a good portion of their time visiting donors and making visits to the CARE International partners. This proved to be a very successful strategy because in the end they raised more than 40 percent in matching funds. In fact by the end of PFPE, the project had raised a 44 percent match.

FUNDING SOURCES FOR CARE'S FAMILY PLANNING AND REPRODUCITVE HEALTH PROJECTS

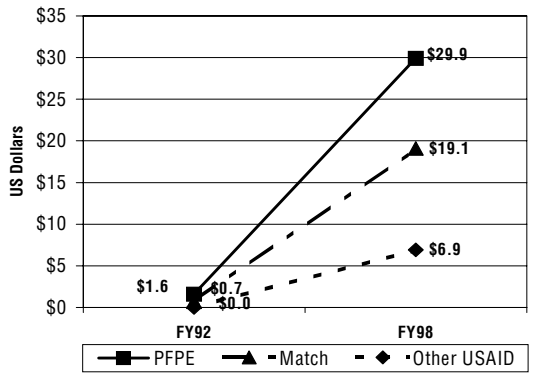
1991-1992
TOTAL: $2,360,818



1997-1998
TOTAL: $17,089,553



CUMULATIVE EXPENDITURES FOR CARE'S POPULATION AND REPRODUCTIVE HEALTH PROGRAM, 1991-1998
(thousands)



CARE UK especially has made reproductive health a priority, in part because of the support and technical assistance received from CARE USA's Population Unit. PFPE resources have supported the development of many project proposals which CARE UK has then submitted to Britain's then USAID counterpart, the Overseas Development Agency (ODA), now the Department for International Development (DfID). ODA/DfID also considers family planning a priority and has responded with numerous grants to projects.

The work that headquarters did in raising interest in family planning among CARE International donors was helpful to the country offices, that in turn were able to raise a significant amount of funds locally through USAID missions and other donors, such as DfID. PFPE's final report shows that close to $19 million in non-AID funds went into the country projects. Field staff commented that because the headquarters staff had developed relationships with CARE International and their donors, they were often able to help local offices secure funding from these donors, or come up with additional funding when they needed it.

Additional funds were raised through CARE USA's marketing department. This department sends out fundraising mailings to individuals as well as information on family planning and reproductive health programs to larger donors such as foundations. As was predicted in the earlier informal survey, the addition of family planning stimulated a positive effect among donors. One of the early direct mail campaigns specifically targeted for family planning received an unusually good response and raised almost $540,000 for the match. Since then family planning mailings have continued to receive good responses. CARE's success in raising matching funds enabled PFPE to expand from the ten projects

CURRENT CARE PROJECTS WITH REPRODUCTIVE HEALTH COMPONENTS BY COUNTRY, TITLE, COMPONENTS AND MAJOR FUNDING SOURCE				
	COUNTRY	**PROJECT TITLE**	**COMPONENTS**	**MAJOR FUNDING**
1	Bangladesh	Shakti	STI/HIV	DFID
2	Bangladesh	Safe Motherhood	MH/NH	CIDA/UNICEF
3	Bolivia	Our Bodies Our Health	FP/MH/STI/HIV	CARE-MoRR
4	Bolivia	Market Networks	FP/STI/HIV	USAID/BHR-PVC
5	Cameroon	Truck Drivers and HIV/AIDS	STI/HIV	DFID
6	Cambodia	Adolescent Health	STI/HIV	UNFPA
7	Cambodia	CARAM	STI/HIV	University Of Amsterdam
8	Cambodia	Jivit Thmey	FP/MH	USAID/Cambodia
9	Ethiopia	Family Planning and HIV/AIDS	FP/STI/HIV	Netherlands
10	Ghana	STI/AIDS Prevention In Mining Areas	STI/HIV (FP)	CARE-MoRR and Gates
11	Guatemala	Mayan Reproductive Health	FP/MH/STI/HIV	DFID
12	Haiti	Reproductive Health 2001	FP/MH/STI/HIV	CARE-MoRR
13	Honduras	Reproductive Health in the Workplace	FP/MH/STI/HIV	Gates Foundation
14	Honduras	Title II Hogasa Project	FP/MH/STI/HIV	USAID/Title II
15	Honduras	Community Agro-forestry Project	FP/MH/STI/HIV	USAID/Honduras
16	India	MISP	MH	CIDA
17	India	INHP	MH/FP	USAID/Title II
18	India	Improving Women's Reproductive Health	FP/MH/STI	CARE-MoRR
19	India	Allahbad Women's Health Project	FP/MH/STI	DFID
20	India	Jabalpur Adolescent Reproductive Health	FP/MH/STI	UNFPA
21	Kenya	Nyanza Family Planning Project	FP/STI/HIV	DFID
22	Lesotho	Footballers Against AIDS	STI/HIV	DFID
22	Madagascar	Community Health Project	FP/MH	USAID/Madagascar
23	Mali	Macina Community Health	FP/MH/STI/HIV	USAID/Mali
24	Mali	Koro Community Health	FP/MH/STI/HIV	USAID/Mali
25	Mozambique	Child Spacing Project	FP	USAID/Mozambique
26	Nepal	Remote Areas: FP and Health	FP/MH/STI/HIV	CARE-MoRR
27	Nicaragua	Matagalpa RH	FP/MH	USAID/Nicaragua
28	Nicaragua	MESA	FP/MH	CARE-MoRR
29	Niger	Zinder Reproductive Health	FP/MH	DFID
30	Peru	Peru 2001	FP/MH	USAID/Peru
31	Peru	Multi-Sectoral Population/DFID	FP/MH	DFID
32	Peru	Multi-Sectoral Population/USAID	FP/MH	CARE-MoRR
33	Philippines	SHINE	STI/HIV	Private
34	Rwanda	Gitarama Reproductive Health Project	STI/HIV (FP)	USAID/Rwanda
35	Somalia	Reproductive Health Awareness and Action	MH/STI/HIV	Mellon Foundation
36	Sudan	North Kordofan Maternal Health	FP/MH/STI/HIV	UNFPA
37	Tanzania	Community Reproductive Health Project	FP/MH/STI/HIV	USAID/BHR-PVC
38	Togo	PFFT	FP/MH/STI/HIV	DFID
39	Togo	PROTECT	FP/MH/STI/HIV	CARE USA
40	Uganda	Community Reproductive Health Education	FP/MH/STI-HIV	CARE-MoRR
41	Uganda	Kumi Reproductive Health	FP/MH/STI-/IV	DFID
42	Uganda	East Uganda Reproductive Health	FP/MH/STI/HIV	DFID
43	West Bank	Jenin Reproductive Health	FP/MH	UNFPA
44	Vietnam	CARAM	STI/HIV	University of Amsterdam
45	Vietnam	Adolescent Health	FP/HIV	UNFPA
46	Zambia	Community Family Planning	FP/MH/STI-HIV	USAID/Zambia

supported by USAID to 35 projects. The success of fundraising for reproductive health even made some staff members nervous. Some people were concerned that donors may be shifting their funding preferences away from some of the traditional sectors in favor of family planning.

In summary, during the first two to three years of PFPE, CARE staff focused its efforts on developing quality programs with strong technical inputs in a small number of countries. They also marketed the program to its internal and external constituencies: country directors, the marketing department, CARE International, donors, and the Board of Directors. They were able to do this successfully largely because they held the funding *checkbook* at headquarters and had control of a large amount of central funding with which to develop the project. This funding also gave them the means to raise more funds from other donors. It also allowed them to provide a large number of technical and administrative inputs to the country projects and made it easy to sell the project to the Country Offices.

B5. Early Challenges in Program Implementation

Some of the difficulties that arose in project implementation had to do with the way the PFPE funding was structured. Because the funds came from USAID's Office of Population, they could only be used for family planning. Yet CARE was a multi-sector development agency that worked at the community level to meet diverse development needs. Because the funds could only be used for family planning and not for other areas, it sometimes became hard to sell at the community level.[2] Experience had shown that going into a community and only offering family planning programming was not always successful. It was often received much more readily when the community had an established relationship with the organization through other programs. Therefore, family planning is often better received when it is offered along with other health and/or development activities. For the most part USAID understood this and that is why they were interested in working with CARE, so that family planning could be offered along with its other activities. The problem was that USAID funds could only be used to support family planning activities and not the other development activities that the communities also wanted. This issue sometimes put the Country Directors in a difficult position. They felt obligated to work with PFPE because family planning was important and so was USAID but they also felt hampered by the restrictive vertical programming.

Another structural issue that affected the field relationships between CARE and the USAID missions was the fact that PFPE was centrally funded. While on the one hand this central funding allowed headquarters to fund projects, technical assistance, materials, and marketing activities which were all crucial to institutionalizing population and family planning at CARE, this same funding mechanism isolated them from the USAID missions in the field. Because the country projects were centrally funded (USAID Washington), the missions did not feel any obligation to monitor them or get involved in their activities, or connect them with the other family planning CAs in the country. The

[2] This situation has evolved at USAID since CARE's new FP/RH project, CARE-MoRR, is supported by a G/PHN Center Cooperative Agreement that authorizes programming in four technical areas: family planning, reproductive health, child survival, and HIV/AIDS.

USAID missions were usually more concerned about keeping track of their own bilateral activities. In some cases, after the missions became aware of PFPE, they took an interest in the projects and included them in the country coordinating committees, etc.

In Nepal, for example, the mission had an interest in developing more programs with the PVOs and bringing them into the population community, so they arranged for a Michigan fellow to work with the CARE program. Similar experiences occurred in Peru and later Bolivia. However, in other countries such as Bangladesh and Uganda, the missions were so busy with their own bilateral programs, that when USAID restructured and reduced the central funding mechanism, the CARE programs were not always funded. Although the USAID missions knew CARE's programs, they were often bureaucratically unable to pick up their funding through mission funding mechanisms. For similar reasons, the CARE project staff often did not connect with the cooperating agencies or other USAID funded activities that were operating in the country. This, at times contributed to a sense of isolation, making the projects more dependent on the local CARE missions and the technical assistance provided by headquarters.[3]

One other issue that affected PFPE project implementation was the fact that most of the headquarters staff, RTAs, and some of the new project personnel lacked CARE field office experience. Because most of these staff had been hired for their technical expertise, most of them came from outside CARE. Even though many of them had field experience with other development programs and usually understood field level technical issues and how to address them, they did not always understand the administrative procedures that affected program operations in the Country Offices. So, when PFPE asked them to come up with match funds, they needed to understand the procedures that the Country Offices followed in order to obtain matches. Most offices needed a year to raise and program match funds, and early in the program this created some tensions between the field and headquarters. The project staff also needed to understand mission budgeting, expenditures, and other administrative procedures, which they often did not learn until after they were hired, and this contributed to delays and confusion in project implementation.

Another issue was CARE's unfamiliarity with the Office of Populations' administrative and contract requirements. This was a new area of USAID for CARE and in the early days unfamiliarity with required procedures created delays and confusion, particularly in the country office financial administration department. To facilitate the adjustment to USAID contractual requirements, the PFPE Project arranged for a budget and grants administrator attached to the project to work with project managers and country offices to assure that they were in compliance with the regulations. The grants officer developed a loose-leaf binder that explained the rules, regulations and procedures required by USAID's contracts office. The headquarters staff also arranged training on financial management and contract regulations to be added on to regular workshops and conferences that were held with project managers.

[3] This situation has also evolved with USAID's restructuring. Today, the USAID Missions have to develop a unified country strategy for their programs, and a centrally-funded initiative must fit into this strategy.

C. Consolidation (1994-1995)

During this period, the PFPE project focused in on its 10 centrally funded country projects and tried to strengthen and consolidate their interventions. At the same time, both CARE and USAID were in the process of changing directions, which had an impact on PFPE. One of the changes, noted earlier, was that USAID began to shift the management and programming of funding for field activities away from a centralized system to one in which USAID field missions have substantially greater authority. In order to respond to this change, CARE had to become more decentralized in its approach to field programs and try to strengthen communication with the USAID missions.

C1. Changes at CARE

One of the big changes at CARE, which actually began in 1993, was that CARE moved its headquarters from New York to Atlanta. One result of this move was that of the six original staff based in New York (three professional and three support), only the senior population advisor, Maurice Middleberg, made the move to Atlanta. At that time, he assumed the role of director. Rebuilding the Population Unit staff took considerable time and energy and was not completed until late 1994.

The new staff represented a strong mix of technical and geographical skills. Carlos Cardenas was hired to fill the position of the senior population advisor. Dr. Cardenas has a medical background and strong Latin American experience. This complemented the other staff who had African backgrounds (reflective of the program's original geographical emphasis). However, one of the staff losses due to this move was not compensated for. The unit no longer had an experienced CARE "insider" on staff who could focus on building relationships across the organization (internal marketing). However, an argument can be made that since the project had by now graduated from its launch stage and was established at CARE, this need was not as strong as it had been at the beginning.

Another change at CARE around this time was the arrival of a new vice president for programs (VPP), Marc Lindenberg. Dr. Lindenberg had an academic organizational management background and was interested in strengthening CARE's technical capacities and engaging the organization in a process of self analysis. He hoped this process would lead to a strengthening of CARE's comparative advantages and a shifting away from programs that were redundant. Dr.

KEY ELEMENTS OF CONSOLIDATION PHASE

- A dynamic headquarters and regional staff evolved to meet field needs (diversified technical skills and regional expertise) and better serve country offices.
- Political support within the organization was useful in encouraging field offices to consider new and innovative programming initiatives, such as reproductive health; and to think strategically about these areas during long-range planning.
- The Population Unit evolved to better integrate country office needs as well as the primary health portfolio. This is reflected in the evolution of PFPE from a "family planning" program to a broader "reproductive health program."
- Successful programming strategies involved improving data management, building on lessons from the mid-term evaluations, and collectively developing future programs based on the recommendations that emerged.
- Headquarters targeted technical support (regional workshops, guidelines, etc.) to areas identified by field offices as important.

Key Lessons

- In order for the momentum to continue within an innovative program with sophisticated technical requirements, continued broad-based support needs to come from within the organization. On-going internal constituency building is needed.

Lindenberg viewed the TAG, which the Population Unit was a part of, as a key player in this analysis process. He was especially interested in the technical innovations and programming methodology being implemented by the Population Unit. He initiated a process in which each Country Office was asked to conduct a strategic planning exercise that examined its portfolio and evaluated whether its programs were in line with the long-range strategic directions being pursued by that office. As part of this process, each Country Office was asked to consider whether there was a need for family planning programming in their stable of activities. Although at this stage, CARE wanted to concentrate on its 10 country projects, this strategic planning exercise helped draw attention to the project and encouraged future expansion of family planning activities to other countries.

C2. Program Development and Innovation

Several programmatic innovations came to light during this period. As noted earlier, one of the objectives of this project was to integrate/coordinate family planning programming with other sectors. At the time of the mid-term evaluation in 1994, nine of the active PFPE and non-PFPE funded family planning projects were clustered with PHC, seven were clustered with ANR projects, five with SEAD projects, and four with food projects. However, the relationship between the projects varied from country to country. Often, as in Uganda, the integration functioned in a *parallel* manner with the two projects operating side-by-side. Coordination and some sharing of resources occurred within the country office structure, but operationally, the projects functioned separately. Another form of integration is what could be termed an *aggregated* model, as was done in Peru. In this case, family planning activities were added to existing CARE programs in other sectors through CARE Peru's Multi-Sectoral Population Project (MSPP). MSPP worked through eight other CARE projects in all four of CARE Peru's other sectors: PHC, SEAD, ANR, and food security. In most cases, because family planning was the newest sector, its integration usually meant adding family planning to areas where CARE already had on-going development projects in other sectors. However, at this stage some of the country programs did start expanding into areas that were not served by other CARE sectors.

Several of the projects were able to take advantage of the programming opportunities afforded by the clustering of family planning with other sector programs. For example, the village outreach approach used to expand immunization coverage in Bangladesh was also used to expand family planning access. The Philippines serves as another successful example of family planning programming benefiting from other sectors. There, the government and USAID asked CARE to use its expertise in logistics, which had been used successfully for distribution of food commodities, to develop a country-wide distribution system for contraceptives. This experience was so successful that the government later added the Expanded Programme on Immunizations (EPI) into this system.

As mentioned above, during the fall of 1994 the eight centrally funded PFPE-funded projects (Bangladesh, the Dominican Republic, Nepal, Niger, Peru, the Philippines, Togo, and Uganda) underwent a collaborative, participatory evaluation process involving all relevant stakeholders. The evaluation, while examining actual versus planned achievements, looked at process rather than outcomes. As another example of the *learning organization* approach, it examined program strengths and weaknesses and tried to sift out important lessons learned and their relevance for future project activities. The process gave

project staff a chance to analyze key elements of success and highlighted program areas that needed further development. These evaluations, though time consuming, were getting stakeholders and others involved in the process involved with the projects.

The results of the mid-term evaluation formed a basis for the 1994 Lessons Learned Conference in Atlanta. During that meeting, participants ranked the existing project elements according to how well they felt CARE implemented them. From strongest to weakest, the program elements were:

- Contraceptive supply
- Counterpart relations
- Quality of care
- Clinical services
- Inter-sector programming
- Training
- Community-based distribution
- Financing
- IEC
- Monitoring and evaluation
- Management development.

After the conference, the project tried to strengthen areas that had been identified as weak. For example, an IEC strategy was developed and several IEC regional workshops were planned that were implemented over the next two years. Also materials were developed. Headquarters worked to improve the monitoring and evaluation systems. Carlos Cardenas, the senior population advisor, set up a system of key indicators to be reported on regularly in the project reports. Project staff had agreed on the definitions of the service statistics and how they were to be measured. A key factor in the success of the monitoring and evaluation system was the vigilance with which Dr. Cardenas monitored progress. He meticulously entered data from the progress reports and regularly followed up on missing reports and data. He also spent considerable time developing a database from which project data could be extrapolated and reviewed. Project staff also began exploring operations research models in order to enhance the quality of the country projects and identify successful approaches.

It was difficult to fully grasp how successful the CARE projects were at this stage in terms of volume of services delivered because many of the projects had only been operating efficiently for a short while. There was a slow start-up period, and there were problems with some of the original project designs (lack of injectables, the need for referral networks, problems with patient recruitment, etc). Project annual reports indicate that by the end of fiscal year 94 (June 95) new acceptors had risen from 32,624 in 1993 to 96,869. CYP had risen from 158,055 in 1993 to 357,392[4].

C3. Final Evaluation

In 1995, the G/PHN commissioned an external evaluation of the CARE PFPE project. The purpose of the evaluation in year four of the five-year project was to examine project performance and accomplishments and provide guidance for an anticipated follow-on project. The final evaluation drew from the findings of the internal mid-term evaluations and the follow-on Lessons Learned Conference. In addition to using data from both these events, the evaluation also included a broader examination of CARE's niche within the USAID strategy.

The evaluation report applauded CARE's success in systematically introducing family planning into its total program. It praised the participatory and strategic institutionalization

[4] CARE worked primarily through community-based distribution mechanisms and made referrals for clinical services. As such, CARE shares credit for this achievement in CYP with other service providers, including the public sector.

process that brought population and family planning into CARE's programmatic portfolio. There were several recommendations for a follow-on project including increased emphasis on IEC, program evaluation, and operations research components. The evaluation also recommended more vigilance in assuring the availability of contraceptive supplies and avoiding outages. It suggested that there be more coordination at the programmatic field level with other population CAs. The evaluators recommended that any future project also require a match but that it not be tied to stringent administrative and expenditure schedules.

The evaluation also clearly recommended that a follow-on project include a reproductive health versus a family planning-only focus. Reproductive health was much more in line with CARE's interest in cross-sector programming and the Population Unit was in the process of developing a reproductive health strategy for future programming. In fact, within the 15 active family planing projects at that time, 11 also had a maternal health focus, 9 had a sexually transmitted disease component, 8 had an AIDS component, 3 included sex education, 2 addressed harmful practices, and 1 addressed abortion complications.

D. Project Expansion (1996-1998)

In 1996, CARE began implementing the first PFPE follow-on project, the two-year *Enriching Lives through CAREful Choices Strategy (Enriching Lives Strategy)*. Although this was part of the PFPE project, the new strategy employed a broader reproductive health approach. This approach was more in line with CARE's emerging cross-sectoral direction as well as with the reproductive health strategy coming into focus in the Office of Population. The strategy continued to maintain family planning as the core intervention. It also identified maternal health and prevention of sexually transmitted infections/human immunodeficiency virus (STI/HIV) as interventions with the most potential for improving health status among CARE's target populations.

D1. Proof of Success

By the end of 1995, the first 10-12 PFPE projects were well underway and had proven to be successful examples of what could be accomplished. Some other CARE missions had already begun family planning projects with non-PFPE funds (for a total of 15 PFPE and non-PFPE projects). Between 1996 and 1998, the family planning and reproductive health portfolio steadily increased. By 1998, CARE was supporting 46 projects with reproductive health components in 29 countries. Of the 46 projects, only the Philippines' project was solely dedicated to family planning. The others included other reproductive health components. Thirty had maternal health components, 26 had STI components (of which 23 also had HIV/AIDS components). There was also considerable overlap with child survival programs in at least eight countries (Bolivia, Cambodia, Haiti, Madagascar, Mali, Nepal, Peru, and Tanzania).

KEY ELEMENTS OF EXPANSION PHASE

- Careful planning and effective use of core money to strategically support field programs—particularly useful in the start-up period when other donor funds may not be available.
- Diverse technical support available from headquarters and regional offices in order to meet field needs in reproductive health.
- As project expands, a strategy is needed to meet the increased demand for technical assistance. If increased staffing at headquarters is not an option, alternatives include regional resources and consultants.
- Expanded monitoring and evaluation system is needed to capture key reproductive health indicators beyond family planning.
- Program innovations, such as NGO/MOH partnering strategies, peri-urban programs, operations research projects, etc., are supported.
- Situated the unit's technical strategy within the organization's overall focus. For example, the Population and Health strategy was linked to the Household Livelihood Security framework.
- Encouraged integrated approaches between health and population sectors early in the project. The placement of the population unit within the organization is key in order to ensure that the unit can develop innovative programming strategies, while staying connected to other sectors that it needs to program with.
- Strong relationships with other sectors in the organization need to be to continually supported. The Population and Health Unit focuses on strengthening the agency's commitment to the unit and preventing itself from becoming isolated.

During this period, CARE substantially leveraged USAID funds. Core PFPE funds enabled CARE to secure an increasing percentage of its family planning and reproductive health portfolio from other donor sources. According to project reports, at the beginning of PFPE in 1992, 70 percent of CARE's family planning programming was supported by PFPE. In 1998, PFPE resources supported only 34 percent of the total programming with 44 percent matched from other donors and 22 percent supported by USAID missions. Although CARE met its match target in February 1997, the match funds continued to increase through the end of the project to a total of over $19 million since 1992. This is a testament to how CARE's

technical expertise, supported by PFPE core funds, made CARE reproductive health programs attractive to other donors.

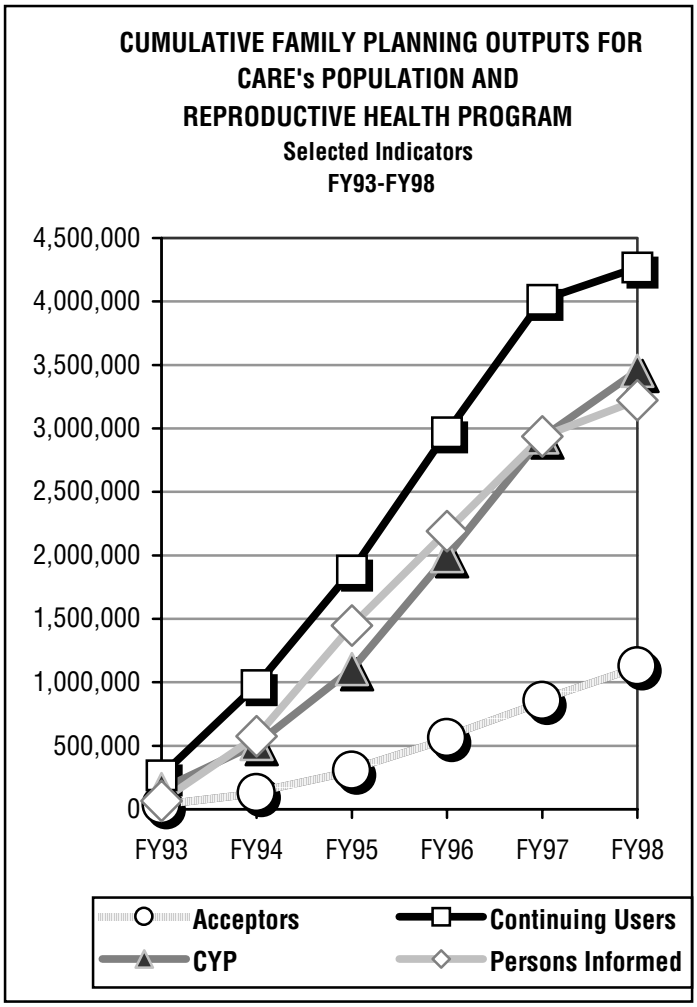
D2. Dissemination of Technical Tools and Guidelines

The headquarters team continued to produce and disseminate technical tools during this period, particularly tools that focused on new reproductive health areas. There were several workshops and conferences. At the *Best Practice 2001 Conference,* CARE brought together staff from 28 countries, donors, collaborating agency staff, and counterparts to discuss best practice standards for family planning, maternal health, STI/HIV, community participation, IEC, and quality of care. There was an *African Maternal Health Workshop* which presented CARE project staff with literature and technical expertise that addressed strategic approaches to maternal health project activities. Workshops on IEC approaches and strategies were also held in Africa and Latin America.

New technical guidelines were produced that reflected the reproductive health agenda. *Promoting Safe Maternal and Newborn Care: A Reference Guide for Program Managers*, summarizes recent scientific literature and programmatic lessons learned with regard to maternal health. *Managing Reproductive Risk Technical Guidelines* presents the best practice (BP) approaches that were discussed at the BP 2001 Conference. The project also produced the *BP 2001: Reproductive Health Conference Report.*

D3. Serving More People

As might be anticipated, the expansion of reproductive health projects into new countries led to a significant increase in utilization of services. The original PFPE family planning service delivery objectives were exceeded. Over one million women began using family planning services, and the project supported more than four million visits for continuing users. Approximately three and a half million years of couple-years protection (CYP) were provided. The information on prenatal and postnatal care, safe deliveries, and STI referrals was less dramatic because CARE only began tracking this during the last year of the project.



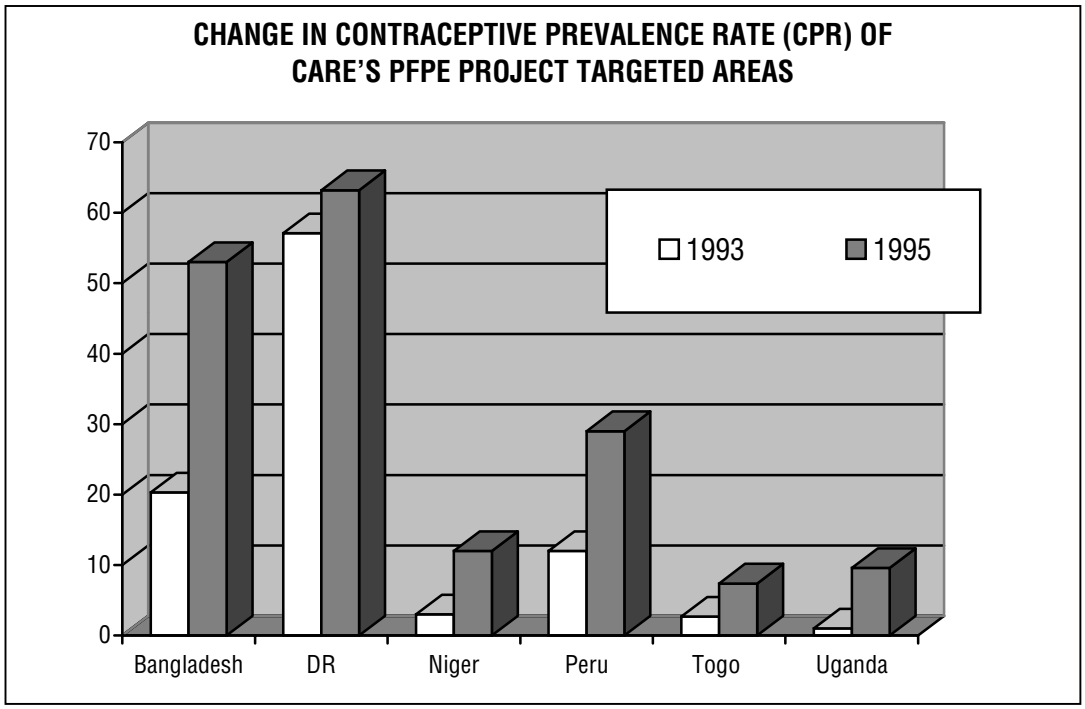
Although CARE's projects have continued to focus on serving hard-to-reach rural communities, there has been an increasing interest in serving the unmet needs of peri-urban communities—particularly during this last phase of the project. There has continued to be a heavy emphasis on partnering with Ministries of Health and local NGOs in both rural and peri-urban projects.

D4. A Model for Families

While the Enriching Lives Strategy was being developed, CARE's TAG unit was developing a new organizational theme—the Health Security Framework. This framework is one piece of CARE's Household Livelihood Security framework which presents a model for integration of CARE's five program areas (income, education, health, food, and community participation). The Health Security approach is focused at the community level. It attempts to help families analyze and limit their vulnerability to health risks. The Enriching Lives Strategy served as a mechanism for helping families manage their health risks by introducing health promoting behavior changes and fostering a supportive environment for reproductive health. At the time this case study was drafted, CARE had come to no final conclusions about how to best apply this framework. It is being reviewed and tested by CARE's health project managers and technical support teams.

D5. Adjusting to Changes

Between 1996 and 1998, CARE went through two changes that affected the Population Unit. The first change involved an organizational restructuring which combined the Population Unit with the Primary Health Unit. The newly created unit was then called the Health and Population Unit. Through this restructuring, the director of the Population Unit became the director of the new Health and Population Unit. This change coincided with the changing emphasis in the PFPE project of moving towards a reproductive health focus and allowed for more coordination between the health and the population staff both at headquarters and in the field. However, there have been some growing pains and it is taking



some time for the new unit to work out its own systems in order to function as an integrated entity.

The second change was the departure, in late 1997, of the vice president for programs. As mentioned earlier, this individual was interested in enhancing the technical aspects of CARE's programming. With his departure and the restructuring, the previous emphasis on the TAG department (now renamed the Program Analysis and Development Department or PAD) has shifted away from that area. More emphasis was placed on the role of the regional directors who directly supervise country directors and offices. Regional managers are also playing a larger role in the technical directions of the country programs.

The situation of the population regional technical advisors (RTAs) provides an example of the impact of these changes. CARE's restructuring led to a decision to do away with the TAG-supported RTAs. However, because the population RTAs were funded by PFPE and served a useful purpose, the Health and Population Unit kept them on in their roles. But shortly after the restructuring, the Asia RTA for population decided to take a job at headquarters. Because the Asia regional manager was not interested in having more RTAs, there has been no replacement for this position.

D6. Some Questions

This situation raises a larger question—What is the best way to structure technical support to a rapidly growing reproductive health program? Between 1996 and 1998, the project expanded from a relatively small number of family planning projects (10) with multiple technical inputs from headquarters and the regions, to a large (46) and growing number of reproductive health projects that do not receive anywhere near the level of technical support that the early projects received.

The 1995 final evaluation also drew attention to the staffing issue, but this has not yet been resolved. The evaluation noted CARE's tendency to maintain an extremely lean headquarters staff—commenting that the six Atlanta-based staff (four technical and two support) would probably not be enough person-power. However, compared with other CARE sectors, the Population and Health Unit technical team is large, and they have a bigger budget than the other sectors. Though the number of technical population staff has not increased during this period of program expansion, the total number of staff in the Health and Population Unit became quite large when the two units combined.

Another issue is that the unit is staffed with a diversity of technical experts, which is different from other sectors. The broad range of technical expertise is justified given USAID and CARE's expectation that the unit will develop a variety of technically sophisticated components and projects. While this technical quality has led to program innovations, it has also created tensions and misunderstandings within CARE. This was true at the beginning of PFPE, and mentioned earlier, and it continues to be an issue in 1998.

D7. CARE-MoRR

This raises the question of how to best address technical needs during the CARE-MoRR (CARE Management of Reproductive Risk)

project[5] particularly if CARE wants to maintain the technical standards it established during PFPE. Headquarters staff realize they will have difficulty meeting the technical needs of 46 projects with only 4 technical staff at headquarters and a dwindling number of regional advisors. They are currently assessing options. Many of the projects are new, and their field staff do not have reproductive health experience to draw from. CARE-MoRR will also seek to address a number of new technical areas in the reproductive health arena that will require sound technical guidance.

[5] The CARE-MoRR project builds on the PFPE project. This three-year cooperative agreement between CARE and G/PHN was signed in July 1998. CARE-MoRR builds on the lessons learned from PFPE and continues to strengthen the cross-sectoral focus. This project will provide a range of reproductive health services as well as child survival services. Networking with local NGOs is another component of CARE-MoRR.

III. KEY EVENTS THAT LED TO INSTITUTIONAL CHANGE

Many events over the last several decades contributed to CARE's institutionalization of the population and family planning sector.

- During the 1970s and 1980s there was **an interest on the part of some members of the CARE Board of Directors** in seeing family planning become a CARE activity. In the mid 1970s, the Board developed a draft policy statement. This statement underwent many iterations until it was formally adopted in 1990.

- In 1989, CARE senior managers (Country Directors and headquarters) participated in **a strategic planning exercise at Tarrytown, New York.** As part of this meeting, CARE examined its organizational capabilities and comparative advantages and concluded that population and family planning programming should be integrated into CARE's existing portfolio.

- The CARE **Board of Directors adopted a population policy statement in 1990**.

- By late 1990, **the CARE Program Manual included a "Population Strategy,"** which presented the rationale, goals, and strategy for CARE's involvement in the sector.

- During 1990, **the Technical Assistance Group (TAG) director (Sandy Laumark) authorized Susan Toole to establish** what eventually became **the Population Unit** at CARE.

- In 1990, Susan Toole and the TAG director wrote **an unsolicited proposal for the financing of CARE's projected population activities**. The proposal was submitted USAID's Office of Population in December 1990.

- **On May 29, 1991, CARE and USAID's Office of Population signed a five-year cooperative agreement establishing the Population and Family Planning Expansion Project (PFPE).** The life of project budget was $32.9 million, with $25.8 million to be provided by USAID and $7.1 million to be provided by CARE. The two major strategies to be used for expanding use of family planning services were: institutionalization of family planning within CARE and expansion of family planning service delivery through CARE's infrastructure.

- **CARE Population Unit established in 1991**. Sue Toole became director of the unit. Four additional staff, including a deputy director, a senior population advisor, and two support staff, are hired at headquarters. Three population RTAs are hired for Africa and Asia.

- After presentations by the CARE Population Unit, **CARE International adopted a Population Policy Statement in 1992**. CI committed to raise funds for family planning projects.

- In 1992, the **first country projects are launched** in Niger, Rwanda, Togo, and Uganda. USAID adopts its "big country strategy," so CARE limits its interventions to 10 country programs instead of the originally proposed 16.

- The centrally funded headquarters **PFPE project was structured to support Country Offices** with Regional Technical Advisors, workshops, technical updates, technical guidelines and standards, and financial support of programs.

- During 1992-93, CARE establishes **additional PFPE programs** in Bangladesh, Dominican Republic, Peru, and Philippines. **Non-PFPE projects are also started** in Bolivia, Guatemala, Honduras, and Mali.

- A series of **technical training workshops and meetings** are held in 1992-93 to increase technical capacity and create a common vision among PFPE project managers. A number of technical guidelines are produced and disseminated to staff to assist with program implementation.

- During 1994, **CARE moved from New York to Atlanta.** The senior program advisor was the only member of the original Population Unit who moved to Atlanta, and he became its director—strengthening the unit's technical focus. **New staff were hired**, bringing different technical and geographical expertise.

- In the summer of 1994, the eight PFPE-funded field projects each organized a participatory **mid-term evaluation** that reviewed each project's progress to date and led to the identification of needed actions.

- In November of that year, PFPE sponsored a **lessons learned conference to focus on the results of the mid-term evaluations**. Among other things, the group ranked the program areas from strongest to weakest.

- An **external final evaluation of CARE**' PFPE project was conducted in the spring of 1995. The evaluation drew on the mid-term evaluations and the conference and documented progress on goals. It made several programmatic and administrative recommendations for the proposed extension of PFPE.

- In 1996, CARE was **awarded a two-year extension of the PFPE project** entitled "Enriching Lives through CAREful Choices". This new strategy incorporated a reproductive health focus that included maternal health and STI and HIV prevention components as well as family planning program activities.

- In the fall of 1997, CARE sponsored the **Best Practice 2001 Conference** which brought together project field staff, donors, collaborating agency staff, and counterparts to discuss standards for family planning, maternal health, STI/HIV, community participation, IEC, and quality of care.

- **PFPE comes to a successful conclusion** in 1998, having exceeded service delivery objectives established at the beginning of the project. CARE also exceeded its match target, and leveraged over $19 million (44 percent of total budget) in matching funds.

- In 1998, **USAID awarded CARE a new three-year project—CARE-MoRR**. The new project continues to strengthen the cross-sectoral focus. In addition to incorporating the reproductive health areas of family planning, maternal health, STIs and HIV/AIDS, the project will also support child survival activities. It includes a component for networking and partnering through local NGOs.

IV. IMPLICATIONS FOR PRIVATE AND VOLUNTARY ORGANIZATIONS (PVOS)

When CARE decided to include family planning programming in its portfolio of activities, it faced numerous issues. How the organization responded to these issues shaped the institutionalization process. This experience has clear implications for PVOs that are expanding into new program areas. Some of these issues are synthesized here.

1. It Was CARE's Decision

One of the interesting facts about the process of institutionalizing family planning at CARE is that the program originated from within the organization itself. No outside donor or other agent encouraged CARE to do it. The interest in family planning evolved out of a growing recognition within the organization centrally and in the field that rapid population growth was undermining the accomplishments and impact of CARE's development work.

The fact that CARE was a development organization in its own right with its own strategy and purpose made it crucial that the commitment to family planning come from inside the organization. Thus, it was appropriate that CARE formulate its population policy before looking for donors to fund the activity. It was also appropriate that CARE require a high level of matching funds as part of the project. That way, it could approach the donors with its own agenda—stressing some of the things they hoped to gain from such an arrangement. In this case, the institutionalization process was a key element for CARE and the integration process that followed allowed them to later push for more integrated programming which led to broader reproductive health programming. The fact that USAID permitted and encouraged CARE to leverage their funds by approaching other donors gave CARE a stronger sense of ownership and control over the direction of the program.

2. Leadership Was Supportive

From the beginning, CARE leadership was obviously interested in family planning. The Board of Directors debated the issue and expressed interest from the mid 1970s until the policy was adopted. After the 1989 Tarrytown strategic planning exercise identified family planning as a priority program area for CARE, Executive Director Phil Johnston was very supportive of this move as was Chief Operating Officer Bill Novelli. Both of these directors supported TAG Director Sandy Laumark in getting the program started. This leadership was very involved in crafting the population proposal to USAID. Because family planning is a political sensitive area, the support of CARE's leadership was key to its ultimate acceptance in the institution. There were also a lot of bureaucratic hurdles that had to be overcome in order to fit the new program into CARE's structure, support from leaders made these hurdles easier to overcome.

3. A Team with High Technical Standards and Organizational Savvy

Something else that was helpful in implementing the program was the composition of the team that CARE put together to organize the program and develop its strategy. Given that CARE did not have experience with family planning programming, CARE looked for staff with family planning experience. Two of the headquarters staff (deputy director and senior program advisor) came from outside CARE

and had previous family planning experience with USAID-funded CAs. However, the director of the unit was a person from CARE and this was an important advantage for getting things moving in CARE. The director's CARE background was key for resolving some of the early challenges facing the program, particularly in the resolution of focusing on technical programming. For example she was able to convince CARE senior management of the importance of hiring technically qualified staff for headquarters, RTA, and in-country program management positions.

The team also decided early in the program that one of the ingredients for selling the population program to the donors (including USAID) and the rest of CARE was to demonstrate success by developing a small number of technically sophisticated programs that could convince country directors about the importance of including family planning programming in their country portfolio. Because this was a departure from the way that CARE programs usually operated, the program unit director's inter-organizational skills were key to getting this accomplished. The final evaluation noted that in the end this worked well since both "... at headquarters and the field, the Population Unit enjoys high credibility and the Unit team has a reputation for quality and responsiveness. Within CARE USA, the development of the population and family planning sector is viewed as a model to be emulated when *operationalizing* girl's education as a sector."

So all in all the team presented some diverse skills that worked well to develop and institutionalize the program. Aside from the director's CARE background, the deputy director had excellent skills for developing successful field programs and the senior population advisor developed many guidelines tools to ease program implementation. He also had a background in advocacy that helped sell the program to donors.

4. A Marketing Strategy

The other activity that the project team did well was develop a strategy for getting the program accepted and funded. The team was aware that this was a new program entity for CARE that required a different program development strategy and that there might be resistance. So, the team mapped the internal and external constituencies that the program needed. These included the Country Directors, CARE International, Board of Directors, key donors, and external relations (CARE's marketing department). They then proceeded to target these groups with different kinds of messages and spent a good part of the first two years making presentations and walking the constituencies through the programs. Headquarters staff also made trips to CARE International partners and made several presentations about the project.

It took awhile to convince CARE USA's marketing department that family planning would be attractive to their donors. Once project staff provided marketing staff with data about the project and its potential, the response was very positive. This marketing strategy paid off because it was after the first two years that the donor contributions started to really come into CARE.

This early awareness of the importance of positioning the project with CARE International and with CARE USA's marketing department has particular implications for other agencies that are beginning to work in reproductive health and are looking for funding from their constituencies.

5. A *Learning Organization* Approach

Part of the approach that was very successful with USAID, especially at the beginning was that of being a learning organization. CARE did not present itself to AID as a highly skilled technical agency like some of the other organizations that AID works with. Instead they presented themselves as a generalist organization that did not have technical expertise but could offer other advantages to USAID. They were an independent development organization with their own global infrastructure. They had country offices with dedicated staff that don't demand the high fees of some of the other agencies that AID works with. The country offices also had contacts and systems in place to get things done in a country, particularly in rural areas.

Because CARE presented itself this way, it was easy for them to say to USAID "look we don't know everything and we're going to make mistakes. When we do we want to be able to come to you and get your help so we can rectify the situation and move forward from there." Fortunately, USAID responded very positively to this approach and instead of criticizing, readily helped when called upon. They appreciated CARE's openness, the high quality of the country staffs, and liked their approach of learning from mistakes. The learning process approach which "embraced error" encouraged the CARE community to take risks, look outside of CARE for needed expertise, bridge research and field work and continually look for experiences to learn more.

6. Selling the Program to Country Offices

In addition to the initial strategy of developing a set of high-quality country programs to serve as examples to other country offices and donors of successful family planning programs, the team also developed an approach to make the project attractive to the field offices. They tried to select countries where CARE country directors were in favor of the program, so that there would be high-level support in-country. Because CARE's headquarters held the central funds for the program, they could offer country offices a fully supported family planning program. In addition, they promised to assist with staff recruitment, project design, training, etc. They also offered a number of technical tools (RTA, workshops, guidelines, and standards) that would help staff develop their programs. In short, they made it easy for the country offices to accept the program and the new technical strategies that they were using to develop it. Later, headquarters staff and RTAs helped country staff write proposals for additional funding of family planning/reproductive health activities.

The project also made serious efforts to disseminate not only technical guidelines for project development and implementation but also to draw upon country experiences and share them with the larger CARE and population communities. Examples of this include the mid-term evaluations that involved multiple stakeholders in the process, the Lessons Learned Conference that drew from the mid-term evaluations, and the Best Practices 2001 Conference which discussed best practice standards for family planning and reproductive health areas.

One of the areas that could have been better developed in the beginning of the project would have been to encourage the field projects to work more with the Office of Population- funded cooperating agencies that were operating in their respective countries. As noted above, this did not always happen in the field because the projects were not usually linked directly to the USAID missions. As a result, USAID and the CARE projects missed some opportunities for collaboration in operations research and services development that would have taken advantage of some of

CARE's strengths in infrastructure and rural programming.

7. Integrated Programming

From the beginning of the project, CARE was interested in fitting family planning into its overall structure. This is part of an evolving institutional strategy of applying a "household livelihood security" model across the whole relief-rehabilitation-development continuum in which CARE operates. The hope is that this approach will facilitate integrated assessments that can focus more on synergies between sectors.

With this in mind, the Population Unit developed a strategy for cross-sectoral programming. As explained above instead of complete integration, this often entailed "parallel" programming, where two or more projects operated side by side, or an "aggregated" model of programming in which family planning was added to existing CARE programs in other sectors such as agriculture, forestry, health etc. It became evident through this programming process that family planning was just one area that these other CARE projects needed. However, because the project was funded through the Office of Population at USAID and because they could only support family planning activities - this presented a challenge. Eventually CARE convinced USAID to support a broader reproductive health (maternal health, STIs, HIV/AIDS) focus under the "Enriching Lives Strategy" and now will be adding child survival programming in the new CARE-MoRR project. The other advantage that this project presents is that it encourages CARE to seek matching funds from other donors, and often these matching funds can be used for broader program interests. Family planning/ reproductive health programs are also being developed in the other sectors at CARE (food/ Title II, girls' education, and agriculture) independent of the CARE-MoRR project.

This push by CARE to seek multiple donors for its projects in order to allow more programmatic flexibility and diversity points out the pitfalls of relying on a single donor. As good as some donors may be, they usually cannot meet all the requirements of the partner organization. Also, the advantage of approaching several donors to fund different aspects of a project is that then the PVO is not dependent on any one donor, and they are more in control of the project.

One of the concerns about the expanded reproductive health focus raised by both CARE and USAID is whether CARE will be able to maintain the high technical standards in their interventions in each of these program areas. The Office of Population and the cooperating agencies with which it worked, used their technical experience to guide CARE. They do not have as long an experience in maternal health, STIs and HIV/AIDS. Another issue is that CARE-MoRR has four professional staff working at headquarters and they do not have expertise in all these areas. CARE is also operating in 29 countries now so even if they did have expertise in all these areas they could not provide the kinds of hands-on technical assistance that they offered earlier in the project. So it looks like CARE's resourcefulness and ability to creatively meet challenges will once again be called upon in this new program. New strategies will have to be thought through and negotiated.

Implications for coordinating with the Global Center for Population, Health and Nutrition. CARE's experience demonstrates that having a strong relationship with the donor can be beneficial to both partners involved. The learning organization approach adopted by CARE facilitated their receiving much technical guidance and assistance in the implementation of the PFPE Project. Also USAID's willingness to support some of CARE's organizational needs, such as

institutionalization of family planning and reproductive health, or integrated programming, strengthened the partnership. However, this was a new relationship for CARE and it required that CARE PFPE staff become familiar with the USAID reporting and administrative procedures both at the headquarters and field levels.

It required that CARE hire staff with technical backgrounds and experience with family planning/ reproductive health. It also required that project staff receive technical assistance and training in administrative and financial procedures as well as in technical areas. CARE had to learn about and become sensitive to the political climate that USAID operates in and the implications that it has on U.S. funding for population activities. CARE needed to become familiar with the terminology associated with the political context such as *metering*, *gag rule*, *Mexico City Policy*, etc., and understand accountability issues vis-a-vis Congress and their implications for the design of family planning programs.

The restructuring of USAID created implications for coordinating with the G/PHN. CARE had to become familiar with the administrative and program requirements created after the center became more programmatically integrated. CARE also became familiar with the G/PHN Center's new mission of global technical leadership and core funding guidelines. These guidelines authorize the use of core funding in three areas: global leadership, innovation, and research.

8. Organizational Issues

Some structural and staffing issues arose at CARE as a result of this process. As noted in the history section of this case study, one of the challenges faced by the project has been that of bringing in a sophisticated project strategy that requires numerous technical inputs, to an organization that has less technical emphasis in its other sectors. This was an issue at the beginning of the project and the project director at the time, skillfully convinced CARE senior management to go along with the technical approach which requires a diversity of highly skilled staff. It also requires more staff to be able to conduct all the hands-on technical inputs required. Between 1992 and 1997, CARE's vice president for programs emphasized the importance of upgrading the technical quality of CARE's programs and used the PFPE program as a model. However, this person has now left CARE and with the restructuring process, the emphasis has shifted away from the strong technical focus. The Population and Health Unit is perceived as very large and unusual because of its strong technical focus and very qualified staff. Yet, if it is going to continue to maintain technical quality in the broad range of new programs being put forth in CARE-MoRR, they will need to work with CARE senior management in order to obtain the additional expertise necessary to address a number of new technical areas in reproductive health, and provide adequate support to field programs.

V. IMPLICATIONS FOR NGO NETWORKS FOR HEALTH

CARE's experience integrating family planning and reproductive health has numerous implications for the NGO Networks for Health project—particularly for potential and existing partners in the Networks Project. A number of the key factors that are likely to be of interest to the Networks Project are presented below.

- There was early and strong commitment at CARE to improving this technical program area before CARE approached USAID for funding. There was also strong support from executive and program leadership within CARE to this initiative, which helped get the program through bureaucratic hurdles. CARE subsequently spent a number of years building upon the organizational commitment to this technical program area and strengthening its current level of technical capacity.
- CARE spent a year developing its proposal to the Office of Population. Once the cooperative agreement was signed, CARE established a strong partnership relationship with USAID, which helped CARE efficiently address and resolve administrative, technical, and program issues during project implementation.
- CARE made a commitment to matching AID funds at a 40 percent level, which ultimately permitted CARE to have a high level of independence in its institutional programming;
- CARE hired a team to develop the project that was composed of people from both within CARE, who understood CARE's way of doing things; as well as from outside CARE, who brought a high-level of technical expertise in population programming. CARE also provided intense technical support and training to project level staff who were charged with leading these technical initiatives at the field level.
- The CARE population program managers in headquarters had early control of project funds and therefore could directly support field projects, RTAs, materials, conferences, etc. It also helped that the PFPE funds were initially "additive" to the USAID's missions yearly budgets. This, together with the technical assistance offered by the PFPE project, made the project very attractive to the country offices.
- Early in the process, CARE's Population Unit developed a conceptual framework which emphasized learning as key to successful program strategies. In CARE, this is reflected by the phrase *embracing error to improve practice.* This approach is demonstrated by the way in which CARE sought appropriate guidance and technical assistance from a variety of external and internal sources, as well as how it examined programmatic weaknesses along with successes, in order to improve performance in this technical area.

This process worked for CARE given its unique organizational context and culture. Every organization has its own way of doing things, and other PVOs considering a relationship with USAID to further develop health and family planning programs may find it useful to review CARE's experiences and reflect on key implications relevant to their organizational context.

The PFPE experience described here illustrates how CARE strengthened its own institutional programming in family planning and reproductive health. While the Networks Project focuses on building and strengthening

PVO/NGO networks, the CARE experience points to several important recommendations for NGO Networks. These are as follows:

1. Developing Commitment is a Process

The Networks Project is based on a unique collaboration among five leading PVOs (the "PVO Partners"). These organizations came together to respond to a request for assistance (RFA) put out by USAID's G/PHN Center.

While each of the Partners had longstanding relationships with other offices of USAID (e.g., BHR/PVC), most were new to the G/PHN Center, and its mission of global technical leadership, its network of over 50 technical cooperating agencies, and its policies.

CARE's experience shows that developing organizational commitment is a long-term process that should be nurtured over a number of years. Similarly, building commitment to family planning and reproductive health programming within the individual partner PVOs, and collectively as a network will take time. This could also be key to the project's success. NGO Networks can play a unique role as "facilitator" to foster the commitment within each partner, as well as to foster commitment to the network (i.e., working collaboratively) and to the Networks Project itself.

NGO Networks needs to pay special attention to this issue over the next year and focus on building strong relationships with each partner PVO. This will include making time and space for learning more about each PVO, and for sharing information and fostering a sense of commitment to the unique network among the PVOs for improving FP/RH/CS/HIV information and services to communities. The Networks Project also has the opportunity to support partner PVO efforts to develop strong and effective working relationships with USAID's G/PHN Center. The Networks Project could also help each PVO Partner to map out internal and external "leverage points" and constituencies, in order to develop an appropriate communication and advocacy strategy for improving family planning and reproductive health programming in each organization.

The Networks Project can play an important role in keeping the Partners focused on these issues via the Managers Working Group (MWG) and the Networks Partnership Council (NPC).[6] Also, a number of key activities programmed in the first year will help achieve this. One opportunity is the PVO organizational assessments, which will help to define how each Partner might begin to foster commitment and capacity in this technical program area. Another opportunity would be through periodic review of the issues with other senior managers from the PVOs. These fora provide a useful way of moving the commitment forward, and keeping the leadership actively engaged on these issues over the next year and beyond. It will be important to realize that these efforts are part of an overall process that will continue over the long term.

2. Develop a Collaborative Relationship with the Donor

The strong relationships that CARE developed with USAID contributed a great deal to the success of the program. The open dialogue began early in the process, and continued over time as CARE developed its program. CARE became familiar with USAID procedures and

[6] The MWG is composed of technical representatives from each Partner, who participate in key technical, program, and management decisions of the Project. The NPC is made up of senior executives from each Partner, and reviews and approves strategies, policies, and plans. It makes recommendations on financial, management, and program issues.

processes (e.g., technical, financial, administrative), and was able to approach USAID for assistance as needed. This went a long way in building a mutually supportive and respectful relationship between the two organizations. Based on this experience, the Networks Project is poised to help the Partners better understand the implications of working collaboratively with the G/PHN Center, and with coordinating effectively with the Center's programming areas (family planning, reproductive health, child survival, HIV/AIDS). The Networks Project should consider how CARE might assist with this, given their long experience and relationship with the Office of Population.

Again, through the Managers Working Group and the Networks Partnership Council, the Networks Project can facilitate a close relationship with USAID, which elucidates for both sides how each is organized and functions, and the implications for programming. Specifically, the Networks Project can help Partners better understand how G/PHN is organized (both technically and administratively), the unique relationship that the Office of Population has with Congress, the political context and implications of family planning/reproductive health programming, and how the Office of Population functions and is linked within the G/PHN. The Networks Project can also help PVO partners better understand the contracting and other administrative procedures used by G/PHN, including project tracking and reporting requirements. This might include providing a general orientation on G/PHN for PVO partners, followed by specific training and assistance in these areas. This should be planned for early in the process to help the Partners avoid later confusion about reporting and other administrative issues.

Another important aspect will be to continue the dialogue with the G/PHN Center. This will mean keeping open the channels for communication and information sharing. For example, the Networks Project should consider making timely and regular presentations at the G/PHN Center to report on progress of activities, lessons learned, new developments, results from operations research, etc. This will allow others in the G/PHN Center to understand the breadth and challenges in the work undertaken by Networks, and will allow for two-way communication, which is key to strong relationships. Networks will need to consider G/PHN's Global Agenda and look at ways to promote the areas of global leadership, technical innovation, and research.

3. Promote Joint Programming and Leverage Funds

CARE had a marketing plan for reaching donors, and drew upon alliances within CARE International to help raise matching funds for the PFPE project. These resources allowed family planning and reproductive health programming to extend within the institution as a whole, and for the project portfolio to grow beyond what was directly funded by USAID. The Networks Project can facilitate dialogue within and among the Partner PVOs, and assist with creative solutions on how the match might be raised and then programmed to best leverage resources. This could include looking at ways to present and market the collaborative activities undertaken by the PVO Partners. Through the Networks Project, the Managers Working Group and the Networks Partnership Council represent important channels for promoting dialogue on these issues, as well as providing impetus for making this happen within the individual organizations. The Networks Project can serve as an example of how collaboration between the PVO Partners can minimize the competition that often arises over funding.

4. Make Staffing Decisions by Looking at the Entire Team

The CARE experience illustrates the importance of having an appropriate mix of staff that reflect the necessary areas of technical expertise, appropriate understanding of the PVO headquarters culture, field realities, and respond to the donor complexities. The Networks Project should carefully consider this issue in terms of its long and short-term staffing needs. The project should also consider a role of promoting the appropriate skills and advising the Partner PVOs on staff profiles as they seek to build their individual technical capacities in family planning and reproductive health programming.

5. Offer Value-Added Technical Assistance

The CARE experience has shown the importance of providing strong technical input to country programs, and this is another area with which the NGO Networks Project can learn how to best structure its technical assistance to partner PVOs. The Networks Project can help to develop a strong technical assistance package for the PVO partners that truly responds to field needs.

Technical assistance can be organized and offered either centrally or regionally, and be made available to the PVOs and their respective Country Offices. The technical assistance services might include compilation of best practices, dissemination of materials, technical training and updates, conferences, seminar series, workshops, and other educational formats. Efforts should focus on making the capacity building opportunities relevant and easily available at the regional or local level, and making them affordable to the Country Offices. Options might include providing high-quality support through Regional Technical Advisors, collaborating with Cooperating Agencies, and developing a consultant roster of technical experts. Related to this, the Networks Project staff are positioned to learn from existing experiences worldwide of service provision via NGO networks, and this will be of great value and interest to the network of PVOs, both at the central and local levels. The Networks Project should also facilitate a dialogue with PVO Partners on how to best respond to the technical assistance needs in the field that might extend beyond the 6-8 focus countries. This would include examining how the Partners might provide this support to the field offices, either directly or in collaboration with one another (e.g., how the match might be used to support capacity building at the field level).

6. Consider the Networks Project as a Learning Organization

The importance of this philosophy is aptly demonstrated by how CARE defined *embracing error* to reflect upon lessons learned to improve and strengthen program approaches. Likewise, the Networks Project has an exciting challenge and role ahead to further this thinking with the network of Partner PVOs. Ideally, the Networks Project should act as a "catalyst" and facilitate a process of experimentation, reflection, and learning among the five PVO Partners, and in the later work at the focus country level with local NGO networks. Using this approach, the Networks Project can play a key role in promoting a healthy synergy among the Partners and the local networks at the country level. Inherent in this approach is the tacit understanding that the Networks Project is also a "learning organization" which will help facilitate a process of capacity building in the PVO and NGO partners.

This can begin with the process of PVO organizational self-assessments and reflection of lessons learned, with a focus on how the

PVO partners might learn from one another, define areas of strength, and ways to complement, collaborate and support each other. The Networks Project can also provide other key input to encourage and promote the value of a "learning organization" and reflect them in how it plans and implements project activities. For example, this can take place through the documentation and dissemination of lessons from the field, providing pertinent technical updates, and sharing of best practices.

Also, the Networks Project is well situated to draw upon the technical expertise of USAID flagship projects, and link this valuable input to programs being supported by the PVO partners, while sharing PVO field perspectives and lessons learned with the flagship projects. Another important role for Networks could be in widely sharing the lessons learned about how networks function (based on case studies from PROCOSI, Groupe Pivot, and other examples) and the role they can play in extending and improving FP/RH/CS/HIV information and services to communities.

7. Build Solid Partnerships

Success in building PVO/NGO capacity in FP/RH/CS/HIV programming is based on good relationships at several levels: with the PVO field offices, with the local USAID Missions, with the PVO partner headquarters, and with USAID's G/PHN Center. Among the PVO Partners, the Networks Project can play an important role in making this happen. The strategies used in Networks should reflect a process to engage the field, respond to expressed needs, and get buy-in both from the PVO field offices and local USAID Missions. Networks can also help the Partners better understand and relate to G/PHN Center, and through dissemination of lessons learned from the field, can promote sharing among the PVO partners. This process should be continuous, and underpin the approach endorsed by the Networks Project—one that focuses technical support to respond to field needs and realities.

ANNEX A

Information on the NGO Networks for Health Project

"*Doing More by Doing it Together*"

What is NGO Networks for Health?

NGO Networks for Health is a five-year global health project, which became operational in June 1998. It is being implemented through a unique partnership of five large non-governmental organizations (NGOs): ADRA (Adventist Development and Relief Agency), CARE, PLAN International, PATH (Program for Appropriate Technology in Health), and Save the Children USA.

Networks will build the technical capacities of these Partner agencies in family planning, reproductive health, child survival, and prevention of sexually transmitted infections including HIV/AIDS (FP/RH/CS/HIV). Partner field offices will join with other community development agencies, and the private and public sectors at the country level to develop and strengthen FP/RH/CS/HIV service delivery networks. As a result, 10-20 percent more people in each of the approximately six *Networks*' focus countries will have access to quality FP/RH/CS/HIV information and services.

What is the rationale for Networks?

If the current level of FP/RH/CS/HIV information and services prevails, there will be substantial unmet need. To meet this need, new collaborative models to expand quality FP/RH/CS/HIV service delivery, such as networks, are needed.

How will it work?

To increase capacity of Partner agencies and networks in focus countries, *Networks* will draw on existing technical resources, especially other USAID-funded projects, which can provide a range of best practices, and tested tools and techniques in FP/RH/CS/HIV programming. Through in-country activities, network members will further test, refine, and take them to scale.

In country, *Networks* will facilitate a participatory field-driven process of network strengthening and development. The Partner field offices and other network members will take the lead in using *Networks* resources to develop and/or strengthen FP/RH/CS/HIV networks in ways that best reflect country-specific needs.

What is the advantage of the Networks model?

Networks will build on the Partner agencies' extensive infrastructure. The *Networks*' local partners have had a longstanding presence in many of the countries that they work in and have developed excellent relationships with the host governments. Because *Networks* will work with local partners in the approximately six focus countries, start-up will be quick. Moreover, *Networks* will draw from a large reservoir of technical resources, especially other USAID-funded projects, to avoid reinventing the wheel.

What are some of the key year one activities of Networks?

Some of the key activities are:

- Building Partner agencies' capacity to carry out higher quality FP/RH/CS/HIV programs in a more collaborative fashion;
- Documenting and disseminating best practices in various technical areas: service delivery networks and networking, advocating for higher quality health programs, and public/private and private/private partnerships;
- Developing and strengthening networks in focus countries.

How is Networks funded?

Networks is supported by USAID's Global Population, Health and Nutrition Center through a cooperative agreement. The cooperative agreement will be implemented by a combination of core funds, mission support funds, and NGO match contributions.

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ANNEX B
Scope of Work

SCOPE OF WORK
CARE DOCUMENTATION

1. BACKGROUND

The NGO Networks for Health Project (Networks) represents a partnership among 5 leading US PVOs: ADRA, CARE, PATH, PLAN, and Save the Children/USA. This project is administered under a Cooperative Agreement between Save the Children/USA and USAID's Global Bureau (Center for Population, Health and Nutrition).

This project seeks to address the issue that community development agencies have not yet fully addressed reproductive health needs within the framework of their programs. Often, efforts in this area of programming are under-resourced, and do not always reflect the best practices in the field of reproductive health. Too often, they have been unable to achieve the scope and scale required to make a significant difference in meeting the urgent need for reproductive health services around the world.

Therefore, a key objective of Networks is to upgrade the FP/RH/CS/HIV information and service delivery capacity of a number of large community development agencies. It will also focus on building networks of organizations operating in tandem in four to six countries, to achieve greater availability, access and quality of information and services for up to 20% of targeted populations. The Networks project will focus on (a) increasing capacity for carrying out reproductive health interventions by the PVO/NGO community; and (b) developing collaborative networks where roles and responsibilities are based on comparative advantage.

When designing the Networks project, USAID drew upon its experiences and investment in 1991 to improve CARE's abilities to deliver family planning and other reproductive health information and services. Since then, CARE has gone through a process to develop and strengthen its capacities in these programming areas. CARE's experience in building organizational commitment to improve its global programs in reproductive health (both in headquarters and the field offices) and the steps taken by CARE to strengthen its technical and programming abilities can serve as one useful example to other members of the Networks project.

This scope of work will document CARE's experiences in building commitment to this area of programming in headquarters and the field, and will describe the processes involved to improve CARE's ability to program effectively in this area. An important part of this documentation will be to frame important issues and questions (emerging from the synthesis of CARE's experience) that might be pertinent to the other PVO partners, as they consider how to address similar challenges in strengthening their efforts in reproductive health programming.

A. Purpose and Objectives

The overall purpose is to document CARE's experiences with building institutional commitment (headquarters and the field) to expanding its efforts in reproductive health, and strengthening its technical capacity to program effectively in this area.

Specific objectives include:

- To provide an example of how a PVO approached the challenge of expanding and improving its global programs in reproductive health

- To synthesize key issues that PVOs might consider when planning to emphasize a new, and potentially controversial, programming area

II. KEY QUESTIONS

There are a number of questions that the consultant should explore as part of the documentation process. This list is not meant to be exhaustive, but illustrates the type of information that will be important to gather during this exercise.

A. Evolution of FP/RH focus in CARE

- How did CARE determine to focus more attention on the area of family planning and reproductive health? Who initiated this process, and how were others in the organization involved in defining and addressing this issue?

- How did the process of focusing on family planning and other reproductive health programs evolve since 1991, and what factors determined and shaped its evolution?

- Where did the decision to focus more attention on these programming areas originate (headquarters or the field)? How did this change take place at the field level?

- How did CARE USA's donors/constituents react to CARE placing more emphasis on this programming area? How did CARE prepare and interact with its key constituents for its increased role in family planning and other reproductive health programs?

B. Building Organizational Commitment and Capacity

- What did CARE do to build organizational commitment to this area of programming? What were the facilitating factors for enabling change to occur in CARE? What were the obstacles to this change, and how were they handled? What approaches worked well in addressing the constraints/obstacles, and which were less successful?

- What/who were the key leverage points in the organization (i.e., the catalysts) to enable change and create the necessary "facilitative" environment for change to occur within the organization?

- What did CARE do to build its technical capacity in this area? How did CARE support related programs and projects in the field?

- Does CARE consider that it has been successful in building organizational commitment and capacity in reproductive health programming? If so, how does CARE define and measure "success". To what extent is this initiative viewed as "successful" both within and outside the CARE health and population unit? What evidence is there that strong commitment to FP/RH programming exists in CARE at all levels?

C. Synthesis of Key Lessons Learned

- What are the key lessons learned from how CARE went about building strong organization-wide commitment to quality reproductive heatlh programming, that might be pertinent to other PVOs? Drawing from CARE's experiences in building organizational commitment and capacity in FP/RH, describe the the key steps in this process, challenges and the lessons learned, to guide other PVOs as they embark on a similar endeavor.

- What are the current challenges faced by CARE as it moves forward to further consolidate and cement its institutional capacity in reproductive health programming?

- Based on the CARE experience, what are important issues for partner PVOs to consider when planning to strengthen and expand programming in family planning and other reproductive health?

III. METHODS AND PROCEDURES

A. Review of Documents

The consultant will review all relevant project documentation related to the CARE Population and Family Planning Expansion project (PFPE). This will include reviewing the annual progress reports, trip reports, and the mid-term and final evaluations of PFPE. The consultant will also review existing program and policy statements that define CARE's position on reproductive health programs.

B. Interviews

The documentation process will largely draw upon a number of key informant interviews, to provide a descriptive history of how CARE has approached building institutional commitment to this programming area, and strengthening technical capacities from headquarters to the field. This will include reviewing staffing structures, funding, and other resources that have supported and facilitated this process within CARE.

The consultant will interview staff from CARE's health and population unit, other staff from headquarters, Country Office staff, and project level staff. It will be important to interview the project managers from those countries where CARE's PFPE began (Bangladesh, Peru, Uganda, Niger, Togo) to understand their perspectives about what worked, what did not, and what made it possible for these projects do succeed.

The consultant will also identify and interview other individuals who were involved in key decisions related to increasing CARE's profile and improving CARE's programming in this technical area. Within USAID/Washington, the consultant will meet with the relevant staff from the Global Bureau, Center for Population, Health and Nutrition. Also, the consultant should interview a few key USAID field staff to get their perspectives on the CARE programs in-country.

C. Visits

The consultant will travel to Washington, DC, to attend a team-planning meeting with selected staff from the Networks Project, and to meet with key individuals from AID/Washington. The consultant will also be required to meet and interview select CARE headquarters staff in Atlanta, Georgia. Input from the field will be collected through telephone interviews and email communications.

IV. MAIN TASKS

- Participate in a 1.5 day team planning meeting (TPM) with Sumana Brahman, Senior Capacity Building Advisor; Elizabeth Bassan, Director, Networks Project; and Carlos Cardenas, Senior Reproductive Health Advisor, CARE. The purpose of the meeting will be to reach a common understanding of the scope of work, and expected end products. The TPM will take place from October 8-9, 1998.

- To review all relevant documents related to CARE's expansion of family planning and reproductive health programs.

- To determine what additional information is needed to document CARE's experience. To prepare key interview questions and format for gathering data.

- To interview selected staff from CARE headquarters and the field; key AID/Washington and field staff; and other individuals who can provide important perspectives and insights into how CARE's program evolved, and the determinants to its success.

- To prepare a draft report that clearly documents how CARE built organizational commitment and capacity in this programming area, and synthesizes the key lessons learned. This report should also draw upon this experience to pose key issues and questions for other PVOs to consider when scaling up activities in reproductive health information and services.

- To share the draft report for comments from CARE, the NGO Networks Project, and USAID/Washington. To finalize the report based on comments received, and to participate in a debriefing on this consultancy.

- To provide a copy of the final report to the NGO Networks for Health Project, with all supporting data and documents, with a copy of the complete report with attachments on diskette.

V. OUTPUTS

- Key questions developed for the interviews (based on input from PVO Partners and Networks team members)
- A synthesis of the key interviews conducted (input of which will be reflected in the final report)
- A report documenting the history of how CARE built organizational commitment and capacity in FP/RH programming (from headquarters to the field). This report should contain specific recommendations/guidance for other PVOs anticipating a similar process.
- Weekly progress briefings/reports on status of consultancy to the Senior Capacity Building Advisor
- A debriefing at the NGO Networks for Health Project

VI. TIMEFRAME

The consultancy will take place in October 1998, and is expected to take a maximum of 22 days (including 1.5 days for the team-planning meeting). The final report is expected by early November 1998. The detailed timeline for this consultancy will be developed during the team-planning meeting.

VII. REPORTING

The consultant shall report directly to the Sumana Brahman, Senior Capacity Building Advisor, and will provide her with regular updates on the status of the consultancy. As Results 1 Manager, Sumana will also be responsible for approving the final report developed under this consultancy.

VIII. QUALIFICATIONS OF THE CONSULTANT

The consultant will have demonstrated experience in evaluating programs of PVOs, and be familiar with how PVOs are organized and managed. S/he will also have experience in health programming or other related areas, and have excellent writing skills. S/he should have very strong analytical abilities, and be able to synthesize key findings and issues, and present them in a clear and concise manner.

ANNEX C
Persons Contacted

PERSONS CONTACTED

NGO Networks for Health
Elizabeth Bassan, Director
Sumana Brahman, Senior Capacity Building Advisor
Premila Bartlett, Communications Advisor
Mike Negerie, HIV/STI Advisor
Theresa Shaver, Safe Motherhood/Child Survival Advisor
Joe Valadez, Senior Monitoring and Evaluation Advisor
Mary Beth Powers, Advocacy Advisor

USAID/ Washington
Duff G. Gillespie, Deputy Assistant Administrator, USAID/Population, Health and Nutrition
Elizabeth S. Maguire, Director, USAID/Population, Health and Nutrition/Office of Population
Paul Hartenberger, Director, USAID/Population, Health and Nutrition/Office of Field and Program Support
Sigrid Anderson, Chief of Division, USAID/Population, Health and Nutrition/Family Planning Services Division
Maureen Norton, Senior Technical Advisor for the NGO Networks for Health Project, USAID/Population, Health and Nutrition/Office of Population
Molly Gingerich, Public Health Advisor, USAID/Population, Health and Nutrition/Office of Health and Nutrition/NMH
Mihirra Karra, former Technical Advisor for CARE's PFPE Project
David Piet, Health Development Officer, USAID/Population, Health and Nutrition/Office of Health and Nutrition/HIV/AIDS

CARE Personnel (current and former)
Phil Johnston, President Emeritus; Board of Directors; former Executive Director
Edwin J. Wesley, Board of Overseers; former Chair, Board of Directors
Maurice Middleberg, Director, Health and Population Unit
Carlos Cardenas, Senior Population Advisor; NGO Networks Partnership Council representative
Susan Toole, former Director, Population Unit
Therese McGinn, former Deputy Director, Population Unit
Sandy Powell, Consultant, former Director of Training Unit
Max Senior, former Regional Technical Advisor, PFPE Asia
Robert Bell, Food Security
Milo Stanojevich, Chief of Staff; former Country Director
Sandy Laumark, Country Director, Angola; former Director of TAG Unit
Doug Clark, External Relations
Reed Thorndahl, PFPE Project Manager, Peru and Nicaragua
Joan Shubert, CARE Niger; former Deputy Director, Health and Population Unit
Dr. Sani, PFPE Project Director, Niger
Diana Altman, former Regional Technical Advisor for East Africa

Other

David Oot, Director, Save the Children/HPN; NGO Networks Partnership Council; former USAID field Health Officer

Abiola Tilley-Gyado, Health Advisor, PLAN International; NGO Networks Partnership Council

Jay Edison, Director for Health, ADRA International/Programs Bureau; NGO Networks Partnership Council

Laurie Cappa, Deputy Director of SEATS Project; former team leader of PFPE final evaluation team

Isabel Stout, Consultant, USAID/Population, Health and Nutrition/Office of Population/Office of Field and Program Support; former team member of PFPE final evaluation team

ANNEX D
Interview Guides

INTERVIEW GUIDE FOR PRE 1991 CARE PERSONNEL

1. How was the decision made and consensus achieved within CARE to move into the family planning and reproductive health program area?

2. What were the strategies used to develop consensus at the different levels within CARE? What were the pitfalls?

3. Where did the decision to place more emphasis on these programming areas originate (headquarters or the field)?

4. How was the decision made to submit the unsolicited proposal to USAID?

5. Who were the champions of the decision? What levels of the organization did they operate at?

6. What was the role of the Board of Directors in this process?

7. What was the role of the Country Directors?

8. What key lessons do you think should be considered by other PVOs who are entering into a similar process?

INTERVIEW GUIDE FOR POST 1991 CARE PERSONNEL

1. Once the decision was made to move into FP/RH programming, how did the CARE leadership go about building organizational commitment and capacity to it, at all levels of the organization? What were the facilitating factors/leverage points that enabled organizational change to occur? Obstacles? How were the obstacles handled? What were the key lessons that you think would be useful to other PVOs?

2. How did the FP/RH programming evolve after 1991? What factors shaped its evolution?

3. How was commitment to FP/RH achieved at the field level? How were field staff brought into the process?

4. How was technical capacity built in this program area? How did CARE support related programs and projects in the field?

5. How was the financial capacity for the program built (i.e. the 40% match)?

6. How was the decision made to involve CARE International in the program? What were the steps involved? What were the advantages of getting CARE International involved?

7. How did CARE/USA's donors/constituents react to CARE placing more emphasis on this programming area? How did CARE prepare and interact with its key constituents for this increased role in family planning and other reproductive health programs?

8. What key steps were involved in creating a successful understanding and partnership with USAID?

9. Does CARE believe that it was successful in building commitment and capacity in reproductive health programming? To what extent is the program considered successful both within and outside the CARE health and population unit? What evidence is there that strong commitment for FP/RH programming exists at all levels?

10. What challenges currently face CARE as it moves to further consolidate its institutional capacity in RH programming?

INTERVIEW GUIDE FOR USAID/WASHINGTON PERSONNEL

1. What was USAID's perception of the advantages of this partnership between CARE and the Global Bureau?

2. How did USAID's interest in CARE for FP/RH programming evolve?

3. What did USAID believe were obstacles for getting consensus on FP/RH programming at CARE?

4. What were the key factors in initiating and sustaining a successful partnership with CARE?

5. How did the USAID see CARE in terms of maximizing the USAID investment in CARE?

6. What do you see as some of the key challenges that CARE faces in strengthening FP/RH in the organization?

INTERVIEW GUIDE FOR
FOR NETWORKS PARTNERS

1. From the partner's perspective, what aspects of CARE's experience in developing an organization-wide support for FP/RH would be most useful to know more about? Structuring? Systems? Funding diversification, challenges ?

INTERVIEW GUIDE FOR FOR CARE FIELD PERSONNEL

1. How did the decision to develop FP/RH programming occur in the country offices? What were key motivating factors?

2. Describe the relationships between the headquarters staff and field staff regarding the building of FP/RH capacity and commitment.

3. What did the headquarters program do to build field staff's administrative and technical capacity? Was it sufficient? What worked or didn't work?

4. How have you seen CARE's FP/RH program evolve over the past years (i.e. not just the technical program elements, but in terms of the type of technical support, administrative support, provided to field programs by the CARE HQ staff)?

5. What improvements might you suggest to strengthen CARE HQ capacity building function for CARE field programs?

INTERVIEW GUIDE FOR USAID FIELD PERSONNEL

1. What was the USAID mission's perception of the CARE PFPE program in the field? What were the obstacles? What was done to overcome them? What were the strengths?

2. What was the USAID mission's relationship with PFPE? How did PFPE coordinate/ intersect with other USAID-funded FP priority projects in-country?

3. What recommendations would you have for other PVOs beginning to work in the FP/RH area with the Global Bureau?

INTERVIEW GUIDE FOR CARE

1. How did the Learning Organization culture evolve at CARE in relation to the PFPE program?

2. How did CARE leverage funding and expand the program on a global scale? How could this be replicated by partners? How could they use this model to advocate for effective use of public funds? Public-private partnerships?

3. How did CARE leverage the match? How did this play out? What are the implications for technical directions?

4. How did CARE diversify its funding? And partner with other donors? (Where did this occur? Field offices? HQ support?)

5. What are the linkages with the Title II programs? How has it worked out?

6. How did the multisectorial focus play out in CARE? (Integration with other programs? - How did it work? Is there any data on cost-effectiveness of this approach [look at the Uganda program]?)

7. How was the monitoring and evaluation system set up for FP/RH? How is it organized? How do they use the data?

NGO Networks for Health (*Networks*) is a worldwide project to improve health services by building or strengthening partnerships at the community level between organizations that are already working there. These partnerships provide a range of services, including family planning, maternal and child health, and HIV prevention, that are relevant to the local situation. This five-year effort began in June 1998, and brings together five development organizations—the Adventist Development and Relief Agency (ADRA), Cooperative for Assistance and Relief Everywhere (CARE), PLAN International, Program for Appropriate Technology in Health (PATH) and Save the Children USA. NGO Networks is supported by USAID's Global/Population, Health, and Nutrition Center.

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